Insurance Company Head Suggests Carriers Experiment With Health Care: See Page 4

Synthetic Turf Does Not Reduce Leg Injuries in School Football: Page 22

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Medical Tribune
and Medical News

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world news of medicine and its practice—fast, accurate, complete

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Direct Implications for Cancer Therapy

Tumor Kept Dormant by Denying Blood

Medical Tribune Report

CLEARWATER BEACH, FLA.—A newly proved ability to maintain a tumor in a dormant state in vivo by denying it a blood supply has direct implications for cancer therapy, the surgeon who did the experimental work reported here.

He is the same investigator who showed in the first place that a solid clump of malignant cells exudes a tumor angiogenesis factor (TAF) that "summons" the growth of capillary vessels to it.

Now, with the new experimental results, said Dr. M. Judah Folkman, one approach to solid tumor therapy becomes the finding of an "antiangiogenesis" agent, perhaps an antibody to TAF.

Dr. Folkman, surgeon-in-chief at the Children's Hospital Medical Center, Boston, reported the latest from his angiogenesis work at the American Cancer Society's 14th Science Writers Seminar.

DR. FOLKMAN

The successful antiangiogenesis experiment was a matter of spatially isolating a tumor so that its TAF had no capillaries near enough to attract. The crucial distance for this is about 3 mm. So Dr. Folkman and associates implanted Brown-Pearce carcinoma in the anterior eye chamber of a rabbit, tethering the implant with a bit of fibrin attached to the back of the cornea. This suspended the tumor more than 3 mm. from the iris, the nearest capillary source.

In this preparation, the implant grows to about 0.8 mm. and then stops. That is

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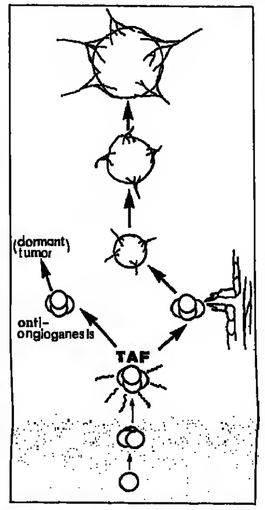

Growing tumor can reach million-cell size without capillary aid. Tumor angiogenesis factor (TAF) must summon capillaries for more growth. Antiangiogenesis, perhaps an antibody to TAF, keeps tumor at pinhead size, fed only by diffusion processes.

Unwary MD Risks Malpractice Suit On Office Surgery

Medical Tribune Report

WASHINGTON—A simple office procedure can expose the unwary physician to a malpractice suit just as easily as the most elaborate surgery.

This was the conclusion reached here in an impromptu comparison of notes between audience and panelists at a session on office surgery sponsored by the Southeastern Surgical Congress.

Whether the patient has come for removal of an ingrown toenail or a sebaceous cyst or for a vasectomy, if the physician is not watchful, the congress participants agreed, he may find himself grimly reading a damage claims document from the patient's friendly neighborhood attorney.

"Most of us don't pay enough attention to the legal aspects of office surgery," said panelist Dr. James E. Davis, Associate Clinical Professor of Surgery at Duke University. "Patients should be informed, not only of what you're going to do but also of what you may find it necessary to do. In our office, we've had the experience of a patient saying to us, 'I didn't know that was what you were going to do.' We now take the time to explain carefully, in advance, and we make sure that a nurse is present. We don't ask for written consent, but we do ask for oral consent."

He stressed: "If the patient is a child, make sure the parents are told what you

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Games Hospital Employees Play

To help orient its employees on new isolation procedures, San Francisco's Mount Zion Hospital and Medical Center used role playing. Nancy Knudson, R.N., hosts panel with "protective isolation bug" (hospital aide Al Prince).

Ultrasonography

Echo Patterns Reveal Kidney Illness Early

Medical Tribune Report

COLORADO SPRINGS, COLO.—Ultrasonography can provide a wide range of information useful in the diagnosis of renal pathology, and the simplicity of the technique makes it valuable for following day-to-day progress during therapy, a regional meeting of the American College of Physicians was told here.

In addition, since x-ray and isotope studies both depend on uptake of dye or isotope by the kidney, ultrasonography is often the only method of evaluation in the severely uremic patient, according to Dr. Joseph H. Holmes, Professor of Medicine and head of the division of renal diseases at the University of Colorado Medical Center.

In polycystic kidney disease, ultrasound gives a very characteristic echo pattern, he declared, and this pattern is often seen earlier than can be detected by other diagnostic techniques. The pattern is characterized by an enlarged kidney outline with interlacing echo lines surrounding irregular clear black areas of different size and shape, he said.

DR. HOLMES

In a study of 64 members of a polycystic-kidney family, 35 had positive diagnostic features for polycystic kidney by ultrasound, while only 15 had a pattern on the routine intravenous pyelogram that the radiologist considered suspicious of polycystic kidney disease, he reported. Ultrasound also picked up the typical pattern of polycystic disease at an earlier age, thus making genetic counseling a feasible procedure, the physician said.

In differentiating between renal cysts and tumors, an accuracy of only about 60 to 70 per cent has been obtained with ultrasonography, but the procedure can nevertheless be helpful in making a decision regarding surgery, he maintained.

Visualization of the kidney with ultrasound can also assist in the proper placement of the biopsy needle, and can be used

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IUD Containing Progesterone Is Backed by a Study of 109

Medical Tribune World Service

GENOA, ITALY—A two-to-10-month study of 109 women has confirmed the efficacy and validity of the intrauterine progesterone device, Dr. Antonio Scommagna of Chicago reported here at an international meeting on **"Medical and Social Problems of Fertility Control."**

Dr. Scommegna, of the Michael Reese Hospital and Medical Center and the Pritzker School of Medicine, said that none of the patients, ranging in age from 18 to 35, conceived while an intact progesterone device was in situ.

Although additional research has to be conducted, he said, the study demonstrated that this device is an "attractive alternative" to both the classic I.U.D. and systemic hormonal contraception.

"A regular menstrual cycle was preserved in all patients, and the incidence of uterine cramps, intermenstrual bleeding, and spotting was markedly reduced, these events being limited mainly to the first month of insertion," he reported.

The Tatum "T" device, developed by Dr. Howard J. Tatum, associate director,

Continued on page 19

Smallpox Vaccination of Hospital Aides Urged

Medical Tribune Report

ATLANTA, GA.—The importance of vaccinating all medical and hospital personnel against smallpox has been emphasized by the Center for Disease Control.

The CDC warning was issued following the spread of smallpox to three general hospitals in Belgrade.

During the recent outbreak of the disease in Yugoslavia, a number of patients were placed in the hospitals without quarantine. This resulted in the closing of the hospitals.

In a memorandum to the American Hospital Association, the CDC asked that its members take steps to make certain all staff members are immunized, a spokesman said.

"Usually, the second generation of smallpox cases occurs in hospitals," the CDC spokesman explained, each incubation period following an outbreak representing a generation.

Vaccine Distribution Reduced

Meanwhile, the CDC noted that a significant reduction in the amount of smallpox vaccine distributed in the United States has occurred since last September, when the Surgeon General of the Public Service recommended that routine smallpox vaccination be discontinued.

A reduction also has been seen in the number of Vaccinia Immune Globulin (VIG) requests for the prophylaxis or treatment of smallpox vaccination complications, the CDC said.

An estimated 75 per cent reduction in the number of smallpox vaccinations given in the U.S. has taken place, it said.

Only four states still have both a mandatory smallpox requirement for school entrance and a state health department policy supporting routine vaccinations.

Drain of Physicians From Britain Found To Be on the Wane

Medical Tribune World Service
From British Edition

LONDON—British doctors may be deciding at last to stay in their own country after graduating.

Latest figures show that for the first time in a decade the percentage of British graduates filling junior hospital posts has risen.

Before this, registrar and senior house officer posts had been increasingly occupied by foreign graduates.

"We think we are seeing the beginning of a change in trend," Dr. Elizabeth Shore, a senior medical officer in the Department of Health, told MEDICAL TRIBUNE.

The rise in senior house officers is quite dramatic. The registrar increase is small, but it is the first time in years that the number has gone up instead of down.

Dr. John Kilgour, also a senior medical officer in the Department of Health, told MEDICAL TRIBUNE that only from a perspective five years in the future would it be possible to tell exactly what is happening.

Brain Drain Drying Up

Present indications, however, are that the brain drain from Britain is drying up. What is more, it appears that more doctors are returning from overseas.

The reasons for the changing trend have not yet been fully analyzed. But one explanation for the waning pull of America is that the money taps for research there are being turned down by an Administration beset by an enormous budgetary deficit. Medical research is one of the most obvious areas for the expenditure cuts.

"This does not mean to imply that there is ample money for research in this country," said Dr. Kilgour. "But the pull of America in terms of money and status has been lessened."

Fear of VD Spread From G.I.s In Australia Called Unfounded

Medical Tribune World Service

SYDNEY, AUSTRALIA—Fears current in Australia at one period that American soldiers on leave from Vietnam would increase the incidence of venereal disease infection have proved unfounded. The "rest and recreation" leave system ended in January after three years' operation.

Dr. E. S. A. Meyers, New South Wales director of health services, told MEDICAL TRIBUNE here that infection turned out to be in the other direction.

"At first there were demands that G.I.s coming here be confined to barracks for 10 days' quarantine and that searching medical examinations be carried out on their arrival at Sydney airport," he said.

"Later, it was the American authorities who sought help from police and public health officials here to prepare a blacklist of Sydney girls transmitting venereal disease to the servicemen," he said. Girls on the list were asked to submit to medical tests and treatment.

Bone Scanner Gives Immediate Result

During testing of bone mineral content with the new device, patient places arm into tank situated above the scanner. Results appear numerically in the readout window, left.

Scanner Measures Absorption Of Gamma Rays, Bone Mineral

Medical Tribune World Service

NYKOEPING, SWEDEN—A bone scanner that measures gamma ray absorption to determine mineral content has been developed here by AB Atomenergi.

It is claimed to be superior to conventional techniques for in vivo bone-mineral determination, such as chemical analysis of small bone samples and roentgenologic examination. A 30 per cent mineral content reduction is often necessary to show a definite indication on an x-ray, without the use of costly photometric methods, the developer noted.

The new device is said to provide a valuable means for detecting a low bone mineral content at an early stage and for judging the effects of medical treatment.

The scanner, intended for both clinical and research use, consists of a scanning module and a control/computer module. Scanning may be either automatic or manual with either one or two isotopes. With one isotope, water is used to eliminate the influence of the soft tissue. With two isotopes, no water is required. However, the scanner is mainly intended for measuring the mineral content of the ulna, radius, and calcaneus, so that the one-isotope method would be commonly used.

Limb Placed in Water Tank

During a bone-mineral test with one isotope, the limb is placed in a plastic water tank on top of the scanner module. The radioactive source emits a collimated beam of gamma rays through the limb to a radiation detector. The gamma beam is moved across the limb a number of times with a predetermined movement sideways between scans. In this way, a considerable part of the limb can be examined.

The control/computer module computes the bone width and mineral content. Values are shown numerically in a readout window also containing a digit position stating the code number of the isotope used.

The bone scanner was said by its developer to have great potential in connection with automated hospital equipment.

Controls Urged for Chemicals Representing a Cancer Hazard

Medical Tribune World Service

GENEVA, SWITZERLAND—A number of chemicals and industrial processes represent such a cancer hazard that their use in manufacturing should be permitted only under license, experts warned in a report to the International Labor Organization.

Restrictions could be applied, for example, to the use of ionizing radiations, beta-naphthylamine, benzidine, and 4-aminodiphenyl, the report suggested.

Products and processes that call for special surveillance include asbestos, chromate ore refining, tars, and mineral oils. The report said that the manufacture and use of carcinogenic substances should be reduced to a minimum and that less dangerous substances should be substituted whenever possible.

The report emphasized the value of automated processes and remote control methods in limiting the hazards involved. The views the report expresses will be used in preparation for the 1973 International Labor Conference, which is to consider international standards for occupational cancer control.

Computer Being Utilized To Diagnose Mental Ills In Italy, Held Accurate

Medical Tribune World Service

PISA, ITALY—A step towards demonstr[ating] that the computer can be applied [to] diagnosis of mental disease has been [taken] at the Psychiatric Clinic of the Univ[ersity] of Pisa here by Dr. Giovanni B. Cas[sano] and a team of psychiatrists.

In a trial of 516 hospitalized pa[tients] the computer accurately diagnosed [the] psychiatric illnesses of 393, or 76 per [cent,] he reported.

The screening was done with a ter[minal] linked to a time-sharing 360/67 IBM [com]puter, using a multidimensional p[sychi]atric scale, composed of about 90 [ques]tions that were put to the patient by [an] interviewer.

Mental State Is Probed

The questions—which can be ask[ed by] nonmedical personnel, Dr. Cassano [said] —probe the patient's mental state and [give] a psychiatric profile that is used by [the] computer to draw up its diagnosis.

The questions include: "Does the pa[tient] speak slowly, carefully, or with diffic[ulty?]" "Does he manifest signs of emotional [ten]sion?" "Does he have difficulty remem[ber]ing events of the last week?" "Does [the] patient try to dominate, control, or lead [the] discussion?"

Of the 516 patients checked by the [com]puter, Dr. Cassano said, 141 cases of [de]pression were diagnosed out of a tot[al of] 186, 27 patients out of 30 suffering [from] mania, 13 out of 20 patients in mixed [psy]chosis, 67 out of 86 schizophrenic pa[tients,] seven out of seven with marginal psy[cho]sis, 96 out of 124 psychoneurotic patie[nts,] 13 out of 16 personality syndromes, [and] 29 out of 47 abnormal psychosis pa[tients].

Number of Women Smokers Ris[es] In Israel, Rate for Men Stead[y]

Medical Tribune World Service

JERUSALEM—The number of women smok[ers] (above the age of 18) here has in[creased] from 13 per cent in 1958 [to ...] per cent in 1970, according to a s[urvey] just published by the Israel Govern[ment] Central Bureau of Statistics. The rat[e] of men (above the age of 18) who s[moked] was 48 per cent in 1970, the same figu[re as] in 1958. Most of the smokers—90 per [cent] of the men and 97.5 per cent of the wo[men] —smoked cigarettes.

European Gynecologists See No Link of 'Pill,' Can[cer]

Medical Tribune World Service

VIENNA—There is still no evidence to link the contraceptive pill with cancer, members of the International Association of European Gynecologists concluded at a meeting here.

At a press conference at the close of the two-day meeting, a spokesman said there was general agreement among members that the pill today is far safer, in terms of possible side effects, than it was a few years ago, while its effectiveness rem[ains] high.

However, the physicians passed a re[so]lution that the pill should not be avail[able] without a prescription, and they also [ad]vised that women taking the pill should [be] examined every three months.

The association groups gynecolog[ists] from all of the countries in the Comm[on] Market, as well as from Switzerland a[nd] Austria.

NEWS INDEX

CLINICAL NEWS NOTE: *"Almost all cases [of aplastic crises] in the present series occurred before the age of 14 years. Only two cases occurred over the age of 14 years."* *(Dr. Graham R. Serjeant; see page 9.)*

FEATURE INDEX

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Pemoline May Aid Child With Brain Dysfunction

Medical Tribune Report

NEW YORK—In the treatment of children with minimal brain dysfunction, a new investigational drug, pemoline, has been shown to alleviate hyperactivity and increase scores on the performance scale of the Wechsler Intelligence Scale for Children, according to a continuing study reported here by Dr. J. Gordon Millichap, Professor of Neurology and Pediatrics at Northwestern University Medical School.

A single daily dose of pemoline, a weak central nervous system stimulant, may be given each morning, offering advantages over methylphenidate and dextroamphetamine, which have a shorter duration and are administered twice daily, Dr. Millichap told a Conference on Minimal Brain Dysfunction sponsored by the New York Academy of Sciences and the National Institutes of Health.

He noted, however, that methylphenidate at present remains the agent of choice.

Among drugs reported in various studies to be of value in the treatment of hyperkinetic behavior and minimal brain dysfunction in children, he reported, the C.N.S. stimulants are the agents of choice. In patients who fail to respond to them, the antianxiety and antipsychotic compounds are recommended as alternative therapies.

"The antidepressant imipramine and the anticonvulsant diphenylhydantoin are also beneficial in some cases, whereas barbiturates, such as phenobarbital, usually exacerbate hyperactivity and are contraindicated," Dr. Millichap said.

The ideal drug, he said, should control hyperactivity, increase attention span, reduce impulsive and aggressive behavior, and have measurable beneficial effects on visual and auditory perception, reading ability, and coordination without inducing insomnia, anorexia, drowsiness, or other more serious toxic effects.

Drugs Listed by Preference

Dr. Millichap listed the drugs reported of value, in order of preference on the basis of efficacy and toxicity, as follows: methylphenidate, amphetamine, chlordiazepoxide, thioridazine, chlorpromazine, deanol, and reserpine.

Methylphenidate, he said, is initiated with a dosage of 0.25 mg./Kg. daily, given in two divided doses at breakfast and lunch. The dose is doubled during each successive week of treatment up to an average optimum level of 2.0 mg./Kg. of body weight daily, "provided untoward effects are not observed." The dosage is monitored on the basis of the responses reported by parents or school teachers and by re-examination of the child after two to four weeks of treatment.

A neurologic battery of tests should be repeated, Dr. Millichap said, at intervals of three to four months in order to measure improvements on perception objectively.

He pointed out that, "in view of the absence of controls in long-term therapy, the treatment should be interrupted at intervals" and the effect of withdrawal observed. A relapse in behavior and deterioration in school grades following withdrawal, he said, are indications for repeated short-term trials.

In patients who develop tolerance to the effects of methylphenidate or those whose parents or teachers report no improvement and whose neuropsychologic tests are unchanged, "an alternative medication, such as dextroamphetamine or imipramine, should be substituted."

Panendoscopy Is Choice Procedure For GI Bleeding

Medical Tribune Report

CARMEL, CALIF.—Panendoscopy—the endoscopic examination of the esophagus, stomach, and proximal duodenum during a single procedure—is the procedure of choice for the aggressive diagnosis of acute upper gastrointestinal hemorrhage, and the routine addition of the "emergency" upper gastrointestinal x-ray series may not be justified in these cases, according to Drs. Ronald M. Katon and Frederic W. Smith, of the University of Oregon Medical School and the Veterans Administration Hospital, Portland.

Use of the endoscope also enhances the work-up of elective cases with epigastric pain, chronic bleeding, or an abnormal upper gastrointestinal series and improves the diagnosis of duodenal ulcer, duodenitis, and other duodenal lesions, they told the Western Section of the American Federation for Clinical Research here.

Panendoscopy was performed on 100 consecutive patients with upper GI bleeding, epigastric pain, chronic occult GI bleeding, or abnormal upper GI series in the absence of symptoms, they reported. Conventional upper GI series were obtained in 97 of the patients.

Bleeding Source Seen in All

In 41 patients with acute upper GI bleeding, the probable source of bleeding was documented by endoscopy in every case, while the "emergency" upper GI series diagnosed only 14 lesions in the 38 patients on whom it was performed.

Endoscopy documented the probable cause in 26 of 41 patients with epigastric pain, while only 10 lesions were seen radiographically. The upper GI series also gave four false-positive diagnoses.

In the 13 patients with chronic bleeding, the probable cause was determined endoscopically in five patients and radiographically in only two. Endoscopy was normal in all five asymptomatic patients studied because of the finding of an abnormal upper GI series, and these cases were considered false-positive upper GI radiographic diagnoses.

Among the 100 patients studied, there were 22 duodenal ulcer patients with documented ulcer craters. Twenty craters were seen endoscopically and only 10 radiographically. Endoscopy appeared even more impressive on reviewing the number of craters per patient, the physicians said. Forty per cent of patients had more than one crater endoscopically, while radiography failed to report more than one crater in any one case. Endoscopy found associated generalized bulbitis in 80 per cent of ulcer patients. Bulbitis without ulcer crater was found in 13 patients endoscopically and in four patients radiographically.

Getting Ready to Travel Again

Recent pacemaker patient, who celebrates 100th birthday this May, watches departures from Newark Airport. Physicians from Newark Beth Israel Medical Center performed procedure. He attributes longevity to walking and a little whiskey before meals.

Man Near 100th Birthday Gets Implant of Cardiac Pacemaker

Medical Tribune Report

NEWARK, N.J.—An Irvington, N.J., man who will celebrate his 100th birthday on May 12 received a cardiac pacemaker implant at Newark Beth Israel Medical Center on March 23.

He planned to fly to St. Louis the week after operation to visit his sister and a son—a trip he has made every two years unaccompanied.

The patient had complained of being unusually tired after his daily five-block walk, but his family had ascribed his complaints to age. When the fatigue persisted, he jokingly suggested that his daughters might "take me to a doctor to get some new blood."

A physical examination showed that he was suffering from heart-block and that the rate of heart beat was far below normal. He was taken to Newark Beth Israel Medical Center, where a permanent battery-powered pacemaker was implanted under the skin in the area of the chest. The next morning the patient was walking up and down the corridor outside his room.

Was Prospector in Gold Rush

The patient, who has two sons, three daughters, 57 grandchildren and great-grandchildren, and a great-great-grandchild, was a prospector during the Alaskan gold rush, a crewman on a whaling ship, and a gambling-house employee in San Francisco in the year of the earthquake. After settling down in Irvington he conducted a moving van business.

The patient attributes his longevity to walking and taking an eighth of an ounce of whiskey before each meal. A hereditary factor is suggested, however, by the fact that a grandfather lived to be 117 years old and an uncle to 100. He will receive periodic checkups in the pacemaker evaluation center at Newark Beth Israel Medical Center.

The physicians engaged in the unusual case were Drs. Herbert Greenfield, associate attending physician, department of medicine, and the patient's personal physician; Edwin Rothfeld, chief of the heart station, who diagnosed the heart-block; I. Richard Zucker, director of cardiodynamics, who placed a temporary external pacemaker prior to the permanent implant; Victor Parsonnet, director of the department of surgery; and Lawrence Gilbert, director of cardiac and thoracic surgery.

Cot Deaths Still a Puzzle; Mouth Derangement Cited

Medical Tribune World Service

LONDON—Cot deaths are still a mystery, Dr. Francis E. Camps, of London Hospital Medical College, told a British Medical Association Board of Science Seminar on Death. Although five children die in this way every day in the United Kingdom, no consistent findings come to light at post mortems, he said.

Broadly speaking, two theories have been popular in the past—the virus theory and the milk allergy theory—but a third theory now seems attractive, he said. This is that cot deaths may be tied up with some neuromuscular mouth-opening derangement.

From the general practitioner's point of view, one of the most important things he has to do is to try to help parents over the profound psychologic upsets that they experience after having had to cope with a "sudden unexpected death of infancy."

Surgeon Moves to Unionize Bay Area Doctors

Medical Tribune Report

SAN FRANCISCO—A campaign to organize a labor union of Bay Area physicians affiliated with the A.F.L.-C.I.O. has been launched by Dr. Sanford A. Marcus, Clinical Instructor in Surgery at the University of California Medical Center here.

He said that he regards the effort as a "public education gesture" at first, but he ultimately expects "a working union, like the teamsters and the longshoremen."

Dr. Marcus, who has his office in Daly City, has written to 5,000 members of the San Francisco, San Mateo, and Alameda-Contra Costa medical societies and has received over 600 replies, most favoring the idea of a union, he said.

He wrote that "the crisis of the American physician" is not merely Government intervention but "the unspoken matter of redistribution of wealth, with many other segments of society tacitly agreeing that physicians are simply making too much money."

"From a position that was once respected and unassailable," he complained, "we have been dragged down . . . , reduced progressively to the role of public functionaries, accorded no more distinction than that given to policemen or letter carriers, subject to the whim of every politician or pressure group."

Even if nationalization of medicine is inevitable, he said, "physicians can and must resist the forces that would literally cut our take-home pay. This can only be accomplished by unionization. . . . What we need is an organization to place a floor beneath our incomes, one that is commensurate with our value to society."

Dr. Marcus disclosed in a telephone conversation that he sounded out both the American Medical Association and the A.F.L.-C.I.O.

He said that the A.M.A. flatly opposes unionization of doctors for any reason, and that an aide to George Meany, A.F.L.-C.I.O. president, told him that a physicians' union is "inappropriate" at present because doctors come under the heading of "employers."

Dr. Marcus quoted Mr. Meany's lieutenant as saying, however, that "in five to 10 years, when most of you are employees, we will be very interested in you."

Physicians' unions have sprung up in a number of American communities—the closest one being in Los Vegas, Nev. There are none in California.

The view of many of these physicians is that they have become part of an "industry" in which third parties have usurped some of their traditional roles, including fee setting and billing.

These physicians refer to themselves as "captive professionals," in the phrase of Paul Goodman, the author. They say they can be compared with barber proprietors whose haircut prices are governed by unions—in their case, by Government, hospitals, and insurance firms.

ECTOPIC BEAT

"Your high blood pressure, your obesity and your alcoholic spouse are all factors in your general health and well-being."

—release from the University of Iowa.

We'll thank you to keep your nose out of our affairs, and a civil tongue in your head.

(Regular beat: Immateria Medica, page 23.)

Dr. Melcher: We're Experimenting in Health Care

Group Health's President Sees Need to Cut Costs

Medical Tribune Report

NEW YORK—"We've looked at a number of unanswered questions and come up with some significant answers," says Dr. George W. Melcher, Jr., president of Group Health Insurance, Inc., a nonprofit insurance carrier with a premium volume totaling $80,000,000, covering 1,400,000, whose state charter was recently changed so that it can now offer health services as well as insurance.

TRIBUNE PERSONALITY REPORT

"We think that financial institutions like this one are in as good a position as the university to undertake experiments in the delivery of health care," Dr. Melcher says.

"We don't think that every answer has to come out of the academic world," he says.

Dr. Melcher explained that with the change in its charter, G.H.I. might now hire physicians and operate a hospital, sheltered housing, an alcoholism center, and a methadone clinic. "We'd like to be involved in their management," he says, "rather than just turning the money over to someone to do it—without any real ability to control things or change things."

The insurance carrier might be able to bring about real reductions in costs if it participated in the operation of a hospital, he says.

"For example, every hospital today provides some outpatient activities whether they be in the form of emergency rooms or laboratories that perform x-ray and laboratory procedures," Dr. Melcher points out. "It has been customary in many areas for a hospital to make a charge for these services that is far in excess of actual costs.

"The hospital's laboratory and x-ray areas have for many years been the prime money-maker for the institution.

DR. GEORGE W. MELCHER, JR.

"It has set the level of charges not in relation to costs but rather at a level that would allow it to generate additional monies to meet the hospital's costs of doing business in other areas where its charges were inadequate."

Know Pieces in Hospital Costs

Adequate management methods and inexhaustive cost analysis might provide a remedy, Dr. Melcher suggests. "We know the pieces that go into hospital costs," he says. "Take the pieces and look at them very scientifically. Control the costs and get more for your money."

At the moment, G.H.I. is setting up the first facility it will operate—a dental clinic, he says. The clinic will be operated by G.H.I.'s affiliate, Group Health Dental Insurance, Inc., which reports a premium volume of more than $21,000,000 covering 930,000 persons.

G.H.I. itself was established in the mid-

He Says University Is Not Sole Source of Answers

1930s as a cooperative in an effort to finance health care for persons of low and moderate income, Dr. Melcher recalls. It provides services through some 11,000 physicians to subscribers who reside in New York, New Jersey, Pennsylvania, and Connecticut.

Its subscribers also include such groups as the recently enrolled 5,500 members of Local 144, Service Employees International Union, A.F.L.-C.I.O., who work in hospitals and nursing homes; 2,342 employees of the Long Island (N.Y.) Lighting Company; 850 employees of the New York Air Brake Company of Watertown, N.Y.; 600 employees of the Grand Union Corporation; and 326 members of Local 6, Restaurant Employees and Bartenders International Union, A.F.L.-C.I.O.

"We have come a long way from the beginning, when we had 16 subscribers and eight physicians and premiums totaled $1,841," Dr. Melcher says.

Dr. Melcher, an energetic gray-haired man, 49 years old, was a practicing internist until last year. He still wears several other hats. He is an Associate Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons; president, National Genetics Foundation; treasurer, New York County Medical Society; and a member of the Council of the International Federation of Voluntary Health Service Funds.

He lives in Tudor City, on East 42nd Street, overlooking the United Nations, a short cross-town trip from G.H.I. headquarters on West 40th Street, which he usually reaches about 7:30 A.M.

The other day, a typical day, he says, he got to the office about that time, then went to a breakfast at the Hotel Commodore with PACT (Provide Addict Care Today), returned to the office about 10:30 A.M. to take care of some routine matters, was interviewed by CBS radio at noon, had lunch, met with Social Security officials from 2 to 5:30 P.M., and then traveled to a Brooklyn meeting with physicians, returning to the office at 10:30 P.M. to work another hour.

He travels a "fair amount"—to look at the operations of insurance carriers in other parts of the country, and to legislative meetings in Washington, D.C.; Albany, N.Y.; and Trenton, N.J.

Will Be Going to London

He will be going to London later this year for a meeting of the International Federation of Voluntary Health Service Funds, at which he will serve as chairman of a discussion on dental insurance.

"England has a system of private health insurance that does certain things the Government omits to do," Dr. Melcher says, comparing the situation abroad with that in the United States. Sweden has no private insurance. Belgium and West Germany have a multiplicity of approaches. Australia has private insurance, with the Government financing part of the benefits. New Zealand has primarily Government coverage, although a private industry has grown up because benefits haven't changed in 30 years."

Born in Portsmouth, Va., Dr. Melcher was graduated from Colorado College with a B.A. in 1943 and from the Columbia University College of Physicians and Surgeons in 1946. He served as a captain in the U.S. Army Medical Corps from 1947 to 1949 and then went to the Columbia Presbyterian Medical Center for his residency. He has been Associate Attending Physician at the hospital since 1960 and Associate Professor at the medical school since 1965.

His association moved gradually from a part-time to a full-time relationship; starting out as an assistant medical director, he was named a senior vice-president in 1965 and president the following year.

For relaxation, he likes to read—"everything in sight on medicine, economics, business, and politics, and the current nonfiction best-sellers"—and run his 1,000-acre farm in Wells, Vt., where he raises sugar maples and peat moss.

SURGICAL NOTES

Coronary Bypass

CLEVELAND—Dr. Jay L. Ankeney, Professor of Surgery at Case Western Reserve University, has developed a method of bypassing blocked coronary arteries with saphenous vein grafts without stopping the heart or using the heart-lung machine. He immobilizes the coronary artery by using a simple network of stay sutures.

The primary advantage of the simplified technique, he said, is its safety. He has used it for more than two years, he reported, and among 144 patients there has been only one death.

The simplified method would be applicable in more than two-thirds of the patients who undergo aortocoronary bypass vein grafts, Dr. Ankeney said.

Vein Catheters Infected

STOCKHOLM—Infected vein catheters were found to be a cause of candidiasis in ... of 22 patients with the disease at East Hospital, Göteborg.

Dr. Tonnes Eilard told the Swedish Medical Society that half the patients were being treated at the surgical intensive care ward following major thoracic surgery with complicated postoperative courses and one-fourth were from the thoracic surgery ward.

Eighteen patients had central vein catheters in use for an average 18 days prior to the first positive blood culture for Candida. Almost all cases had received multiple antibiotic therapy for an average 21 days prior to culturing. Ten patients had been treated with steroids or immunosuppressive drugs.

Candida was isolated in the blood of 11 patients during only one day's culturing. In all cases in which cultures were made of the removed catheter tip, the same type of Candida found in the blood was demonstrated.

Bypass for Shock

SASKATOON, SASK.—Emergency aortocoronary bypass graft surgery can sufficiently alter the pathophysiology of cardiogenic shock from myocardial infarction to salvage otherwise doomed patients, an Ontario heart surgeon reported to the Canadian Cardiovascular Society.

Describing success with four of six patients in a year, Dr. Wilbert Keon of the Ottawa Civic Hospital, stressed that coronary angiography needs to be done to establish the feasibility and location of the bypass, and it must be done within the operating room, to maximize chances of survival.

The patient in cardiogenic shock could not normally be expected to survive being moved any distance from the angiography room to the operating room, he said, and this is the main reason for lack of success with the bypass as an emergency procedure in other centers.

Pain Relief by Barbotage

OXFORD, ENGLAND—A technique of barbotage has produced substantial relief in about 75 per cent of patients suffering severe pain as a result of malignant disease, according to *Dr. J. L. Lloyd*, of the Abingdon Pain Relief Unit of the United Oxford Hospitals.

Dr. Lloyd told MEDICAL TRIBUNE that the duration of pain relief varies from about two days to approximately three months.

The barbotage technique is virtually the same as for lumbar puncture. Premedication with meperidine and promethazine is given an hour before barbotage and before inserting a large-bore Touhy needle into the spinal theca through the L5-S1 interspace.

An intravenous injection of 5 mg. of diazepam is given just before the operation commences. About 10 ml. of cerebrospinal fluid is withdrawn and immediately replaced, and the process is repeated 15-20 times.

What's new and important in the area of tumor immunity in man?

The Consultant

DR. LOREN J. HUMPHREY
Professor and Chairman, Department of Surgery, University of Kansas Medical Center, Kansas City.

THE REAL PROGRESS made in tumor immunity in man is a direct result of laboratory studies. This development has occurred because of the application of basic immunologic techniques to clinical investigations of patients with cancer. It is important to place this in its proper context by realizing that tumor-specific immunity was first demonstrated in animal-tumor models using inbred strains of animals and tumors induced in the strain of origin. This type of experimental model was significant in convincing the scientific community that tumor-specific immunity does exist, that it is weak and therefore effective therapy, using host resistance, is tumor cell–dose related. Hence, studies on the cancer patient use a model in which the host is a mongrel and the tumor is autochthonous. For the immunologist, this type of host-tumor model renders the proof of tumor specificity extremely difficult.

There have been several immunotherapy trials, and yet at this time there really is no true therapy as such. However, these experimental programs, when backed by proper laboratory evaluation of the response to manipulation of the immune system of man, have played a key role in progress to date. Curiously, the response to manipulation of the immune system is approximately 5 per cent seen in most clinical investigations and regardless of the type of "immunotherapy." This observation further emphasizes the point that the measurement of the serologic and cellular response of the cancer patients has been the important area of progress so far and very likely holds the keys to progress.

What are the important developments in the measurement of tumor immunity in man?

Of foremost importance in immunologic studies on cancer patients is the demonstration that antibody and cellular activity against allogeneic tumors has been observed by use of several different in vitro test systems. Antibodylike activity has been demonstrated in the serum of patients with almost every type of tumor. However, a lot of work remains to be done to show that this activity is due to antibody, as well as the specificity and class of antibody involved. More important is the observation that antitumor antibody in serum increases after removal of tumor or after immunization with tumor. Dr. Morton has demonstrated a relationship of residual tumor and/or recurrent tumor with antibody titer using complement fixation tests.

In our laboratory, we have demonstrated by complement fixation tests, as well as primary culture inhibition tests, that antibody titers can be increased by stimulation of the host with a tumor homogenate. At the same time, we have shown reactivity in complement fixation and immunodiffusion with the cell sap fraction of tumors. This is somewhat unexpected on the basis of transplantation immunity, but from electron microscopic studies this may be due to pieces of cell membrane in the postribosomal fraction and not necessarily due to some intracellular or sequestered antigen. Other tests, such as the test for carcinoembryonic antigen, are highly important and interesting. Much work is needed to ascertain their role in clinical testing.

It is very important to point out that no one to date has convincingly shown tumor specificity in man and indeed, all of the antigens detected may be tumor-characteristic rather than tumor-specific. This, of course, does not in any way decrease their significance, as they are excellent research handles for continued progress in tumor immunity studies.

The various skin test antigens employed in cancer patients in which, as you know, there is an anergy in the terminal patient, leaves interpretation open to question. This anergy may not be of specific tumor immunologic deficit but may be a general defect of the host.

Are corticosteroids and other immunosuppressive agents contraindicated in the treatment of patients with neoplasia?

No; I do not feel that either corticosteroids or immunosuppressive agents are contraindicated in the treatment of patients with cancer. We have all seen them used effectively, and, of course, the chemotherapist as well as the immunologist has always worried about the immunosuppressive effects of corticosteroids and the anticancer drugs. The fact that they are immunosuppressive does not imply that they should not be used. On the other hand, I think, with proper in vitro backup in using these different agents in the future, we will be able to use these much more selectively in a way that perhaps avoids immunosuppression to the point of offsetting some of the cytotoxic effects of the drugs. This is a very important area of future research.

Although the application of tumor immunity is experimental, are there any clinical situations where it might be currently indicated?

First of all, in any type of experimental immunotherapy program, one must be extremely careful to protect the patient's welfare. For instance, enhancement, exclusion of preferred treatment, etc., must not be overlooked. Hence, in those clinical situations in which cancer patients are in a state of immunologic unresponsiveness, the application of immunotherapy would seem indicated. By this I mean that it is ethical to carry out immunotherapy trials if there is no other effective treatment for the patient, but I do not consider it ethical just to use immunotherapy. Any experimental immunotherapy program must be backed up with a sophisticated laboratory capable of evaluating what is being effected by immunotherapy.

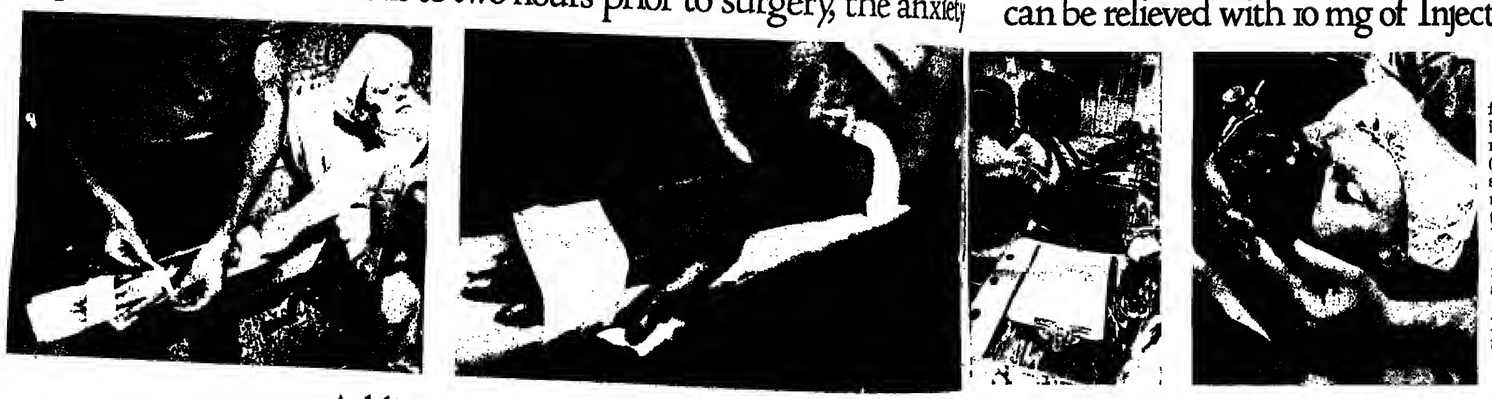
Next In Consultation

DR. SAMUEL LIVINGSTON, Director and Physician-in-Charge, Epilepsy Clinic, Johns Hopkins Hospital, Baltimore.

...will answer such questions as:

- What is his approach to a young child who has had a febrile convulsive episode?
- When is diphenylhydantoin contraindicated as drug of first choice in the treatment of epilepsy?

If the patient is overanxious one to two hours prior to surgery, the anxiety can be relieved with 10 mg of Injectable Valium (diazepam) I.M.



Additionally, Injectable Valium (diazepam) can diminish recall of the preoperative procedure.

Injectable Valium (diazepam) is a useful premedicant for reducing undue anxiety. Recall of preoperative procedures is markedly diminished. When given in conjunction with narcotics, a reduction of narcotic dosage should be considered. (See summary of prescribing information.) Injectable Valium should not be mixed with other drugs, solutions, or fluids. The new 10-mg disposable syringe can help you observe this precaution at the same time it helps assure aseptic handling. Injectable Valium seldom significantly alters vital signs. Nevertheless, there have been infrequent reports of hypotension and rare reports of apnea and cardiac arrest, usually following I. V. administration. Resuscitative facilities should be available.

To relieve excessive preoperative anxiety, remember Injectable Valium (5 mg/ml)—2-ml ampule, 10-ml vials, and the new 2-ml Tel-E-Ject™ (disposable syringes).

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; tetanus; status epilepticus and severe recurrent seizures; anxiety prior to gastroscopy, esophagoscopy, and surgical procedures; cardioversion (I.V.).

Contraindicated: In infants; in patients with known hypersensitivity to the drug; in acute narrow angle glaucoma; may be used in patients with open angle glaucoma receiving appropriate therapy.

Warnings: *Inject I.V. slowly, directly into vein; take at least one minute for each 5 mg (1 ml) given. Do not mix or dilute with other solutions or drugs. Do not add to I.V. fluids.* Rare reports of apnea or cardiac arrest noted, usually following I.V. administration, especially in elderly or very ill and those with limited pulmonary reserve; duration is brief; resuscitative facilities should be available. Not recommended as sole treatment for psychotic or severely depressed patients. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs. Caution against hazardous occupations requiring complete mental alertness. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard to mother and child.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Not recommended for bronchoscopy, laryngoscopy, obstetrical use, or in diagnostic procedures other than gastroscopy and esophagoscopy. Laryngospasm and increased cough reflex are possible during gastroscopy; necessary countermeasures should be available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Since effect with narcotics may be additive, appropriate reduction in narcotic dosage is possible. Use lower doses (2 to 5 mg) for elderly and debilitated. Safety and efficacy in children under 12 not established.

Side Effects: Drowsiness, fatigue, ataxia, confusion, depression, constipation, dysarthria, diplopia, headache, hypoactivity, hiccups, hypotension, incontinence, jaundice, nausea, changes in libido, changes in salivation, phlebitis at injection site, urinary retention, skin rash, syncope, slurred speech, urticaria, tremor, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy. Minor EEG changes, usually low-voltage fast activity, of no known significance.

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Pneumocystis in Lungs: Early Therapy Urged

Medical Tribune Report

TAMPA, FLA.—The necessity for early histologic diagnosis of Pneumocystis carinii pneumonia and the effectiveness of prompt specific treatment in altering the course of the disease were stressed at a Southern Thoracic Surgical Association meeting.

Seven of 11 patients who had lymphoreticular disorders or were undergoing immunosuppressive drug treatment and developed Pneumocystis pneumonia were long-term survivors after treatment with pentamidine, according to Drs. Glenn W. Geelhoed, Barry J. Levin, Paul C. Adkins, and William L. Joseph, of the George Washington University Medical Center and the National Institutes of Health.

Two other patients died of their underlying disease a month after treatment but showed no evidence of Pneumocystis pneumonia at autopsy, they reported. The remaining two patients died 18 hours after therapy began and after a full course of therapy, respectively.

After negative bronchoscopy and sputum studies, seven of the patients had undergone needle biopsy, which was diagnostic in four. The other three had definitive diagnosis made by open lung biopsy. The remaining patients were diagnosed by classic x-ray. Treatment dose was pentamidine 4 mg./Kg. daily given for an average of 10 days.

The investigators said that they had established a diagnosis of Pneumocystis pneumonia in 27 patients over a 25-year period. Before pentamidine therapy was in use, nine patients had succumbed to respiratory failure with a diagnosis unsuspected clinically but proved at autopsy, and six of seven patients in whom the clinical syndrome was recognized died of progressive respiratory insufficiency despite treatment with amphotericin.

Clinically More Significant

Although previously considered to be an opportunistic infection of premature infants and debilitated adults, Pneumocystis pneumonia has become clinically more significant in all patients with impaired cellular immunity, they emphasized.

If a relentlessly progressing interstitial pneumonia develops in such patients treated with corticoids, chemotherapy, or broad-spectrum antimicrobials, the diagnosis of Pneumocystis pneumonia must be suspected, they said.

"The characteristic clinical triad of progressive respiratory failure, diffuse hilar infiltration, and minimal auscultatory findings should call for tissue confirmation of the diagnosis," they declared.

"The diagnosis can only be made by histologic examination of the lung, and biopsy is essential," they asserted. "Histologic diagnosis must be established before treatment is instituted, because effective therapy is sometimes toxic."

Patients with severe pulmonary insufficiency in Pneumocystis pneumonia require some type of prolonged respiratory support. "Prolonged extracorporeal pulmonary support with a membrane oxygenator can provide satisfactory oxygenation during the critical initial period before therapeutic levels of pentamidine are attained," they said. "In addition, the membrane lung would eliminate the possibility of lung parenchymal damage as a result of prolonged high-oxygen ventilator support."

Two patients supported by the membrane lung attained satisfactory systemic arterial oxygen saturation, the investigators said. Problems with heparinization necessitated early discontinuation of the artificial lung in one patient, while the second had a more desirable response.

Editorial Capsules

... brief summaries of editorials or guest editorials in current medical journals.

The skin and the central nervous system derive from the original ectoderm. We would do well to remember this common ancestry, which could bring to the quicksand of psychosomatic dermatology the rigor and substance that it lacks. Editorial. *(Concours Méd. 94:3, January 15, 1972.)*

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There have been a number of studies on the incidence of Giardia lamblia in Scandinavia. Figures vary from 4 per cent to 8 per cent, with a higher frequency among children. Despite the fact that Giardia occurs in healthy persons, it is becoming increasingly clear that it can give rise to GI afflictions, usually acute or chronic diarrhea, and sometimes also malabsorption. For one thing, Giardia is more common in healthy persons. For another, epidemiologic investigations point to a relationship of acute diarrhea to Giardia infection.

Patients with undetermined abdominal disturbances arising here (Norway) or abroad should first of all be checked for the presence of pathogenic intestinal bacteria. If Giardia is found when thorough examination reveals no other causes, treatment for this infection is in order. Idaline, editorial. *(J. Norwegian Med. Assn. 92:6, February 29, 1972.)*

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Which measures would be most effective in reducing the alarmingly high child mortality in developing countries? We should first of all bear in mind that this mortality is mainly the result of diseases that can be prevented. And these, in turn, arise from the well-known "tropical" causes that are less dependent on climate and more dependent on such factors as poverty, ignorance, poor hygiene, deficient diet, and minimal health care resources.

Technical assistance, bilateral and multilateral, can play an important role here, but it is the developing countries themselves that must amass the necessary resources. By and large, health departments have found it difficult to compete for their share of modest national resources. It is not at all uncommon for the budget of a health department to be no more than one fifth the budget of a defense department. Editorial. *(Läkartidningen [J. Swedish Med. Assn.], 69:8, February 16, 1972.)*

↓

A feature of Japanese medicine is that specialization is left to the individual physician. Thus, an otorhinologist can examine pulmonary functions; he can perform gastric endoscopy and treat a patient with gastric ulcer. The internist is the physician who comes closest to the Western concept of general practitioner; his services are associated with the widest range of medicine. As further specialization develops in medicine to meet the increasingly specialized demand, the internist will have a new role. He will become a primary physician with specialist status. H. Irie, editorial *(Japan J. Int. Med., 29:3, February 1972.)*

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During recent years, powerful voices have emerged in favor of a rapid development of clinical pharmacology in Danish hospitals. The question is whether we should not, as soon as possible, expand our goals in this area to include a massive effort aimed at securing the necessary clinical-pharmacologic assistance for the primary physician's service.

Physicians in general practice are often reproached for falling easy prey to the various sales techniques of the pharmaceutical industry. But haven't we really let the primary physicians down in this regard, leaving them to find for themselves the norms for medicinal therapy in general practice that enable them to work with reasonable safety and effect? Erik Holst, editorial. *(Ugeskrift for Laeger [J. Danish M.A.], 134:4, January 24, 1972.)*

Sickle Cell Anemia Believed To Differ With Environment

Medical Tribune Report

NEW YORK—Prolonged survival of patients with homozygous sickle cell anemia is a feature of the disease in Jamaica, and this may be accounted for by environmental factors, according to Dr. Graham R. Serjeant, of the University of the West Indies, Kingston.

Dr. Serjeant reported here on a comparative study of the clinical and hematologic features in a group of patients over 30 years of age and a group under 30 years. "There were no obvious differences in hematological features, but the decreasing incidence of active leg ulceration and painful crises in older age groups suggested an amelioration of the disease symptoms with age," he told a Symposium on Sickle Cell Disease.

438 Cases Were in Study

In the study were 438 cases of homozygous sickle cell disease, the patients ranging in age from 10 to 62 years. One hundred and twenty-one of the patients were over the age of 30 years, and these included 43 over age 40 and 13 over age 50 years.

Leg ulceration, which he said is one of the commonest features of sickle cell anemia, eventually affected about 75 per cent of the patients. It usually occurred for the first time between the ages of five and 19 years, he said, but was uncommon after the age of 30. Its incidence fell in the older age groups, "partly because of the emergence of a benign population without leg ulceration but mainly because of a tendency for leg ulcers to heal with advancing age."

The incidence of hospital admissions for painful crises also fell with age, he reported. The attack rate, expressed as a percentage of admissions for those at risk in each age group, fell from 37 per cent in the 15-to-19-year group to 3 per cent in the 35-to-39-year age group. "There were no admissions for painful crises in cases over 40 years," he noted.

Aplastic crises, Dr. Serjeant said, appear to be primarily a pediatric manifestation. "Almost all cases in the present series occurred before the age of 14 years," he reported. "Only two cases occurred over the age of 14 years, one at the age of 23 and another case presented for the first time at age 32 with an aplastic crisis."

Dr. Serjeant pointed out the disease in Jamaica presents with a wide spectrum of clinical severity, ranging from severely affected patients with frequent complications and death at an early age to cases so benign as to remain unsuspected and undiagnosed. "It seems unlikely," he said, "that the apparently benign clinical course of sickle cell disease in Jamaica could result from the selective distribution of a benign variant. Neither is it likely that a benign mutant has been naturally selected to this extent in a period of 300 years." He said, however, that the recent description of apparently benign variants of homozygous sickle cell disease, such as Hb S/Memphis, "stresses the need for more widespread studies of molecular structure and a search for new or additional amino acid substitutions."

Dr. Serjeant pointed to several environmental factors, already known, that "might be expected to promote survival" of sickle cell patients in Jamaica. The mean high temperature and small annual variation make unlikely peripheral vasoconstrictive phenomena that may be important in the genesis of the painful crisis. Cold, he noted, is a recognized precipitating factor in painful crises, "and it is not uncommon for severe crises to affect a previously benign case on emigration to England or to North America."

Playing Population Game

"Planafam II," a game intended to educate its players on population-planning problems, has been developed by Harold Thomas, Jr., S.D., and Dr. Katherine Finseth (above), of Harvard.

Better Detection of Drug Interactions Asked

Medical Tribune Report

PHILADELPHIA—The need for faster and more effective epidemiologic and experimental techniques for the detection of drug interactions was stressed here by Dr. Jan Koch-Weser, chief of the clinical pharmacology unit at Harvard Medical School and Massachusetts General Hospital.

"The past pre-eminence of chance clinical observations in the growth of our knowledge about drug interactions reflects the general lack of rational and organized investigations in this field, rather than the effectiveness of serendipity," he told a Symposium on Drug Interactions, held by the Drug Information Association.

Chance observations are a slow and inefficient method of obtaining information on drug interactions, he declared.

The clinical situation is often too complex to allow recognition of an unexpected event in a patient's course as being related to his drug therapy, Dr. Koch-Weser pointed out. In addition, most practicing physicians have a low index of suspicion concerning drug interactions. Even when unusual occurences during drug therapy are recognized, the physician, for a variety of reasons, often fails to report them.

Reporting Remained Incomplete

During six years of clinical studies of drug interactions at Massachusetts General Hospital, recognition and reporting of drug interactions by clinicians remained very incomplete in spite of continuous educational efforts emphasizing the clinical importance of drug interactions and urging practicing physicians to report all drug interactions, Dr. Koch-Weser said.

The slowness of recognition of drug interactions by practicing clinicians is also well documented historically, the investigator said. For example, the detection of the interaction of barbiturates with coumarin anticoagulants came only after 15 years of concomitant administration of the two types of drugs, and another 10 years passed before the quantitative importance and mechanism of the interaction was understood.

This long delay occurred in spite of the fact that the two drugs were very commonly administered together and their interaction was clinically important in every patient. The morbidity and mortality due to the interaction during the many years before its clinical recognition must have been distressingly high, Dr. Koch-Weser remarked.

The newer epidemiologic and experimental techniques for detecting adverse drug interactions have been employed only during the last several years, but their effectiveness is already clear, the pharmacologist said.

Prospective epidemiologic studies of hospitalized or ambulatory patients can identify almost all types of drug interactions much more readily and reliably than random observations, he declared.

In one such study, 500 patients hospitalized at Massachusetts General during the past three years were prospectively monitored while they were receiving sodium warfarin.

The study yielded "quite conclusive and quantitative" data about the interaction or lack of interaction of 54 drugs with warfarin, and the most dramatic interactions were detected even when only a few patients received the drugs concomitantly, Dr. Koch-Weser said.

While such prospective epidemiologic studies require considerable effort and are not inexpensive to perform, their over-all cost-information ratio should be far lower than that of large-scale programs relying on spontaneous reporting of chance observations, the physician remarked.

An alternative approach is the prediction of drug interactions on the basis of the pharmacologic action or metabolic fate of the drugs used. Such predictions can be safely and conclusively verified and their quantitative characteristics established by controlled studies in a small number of normal volunteers or patients, Dr. Koch-Weser said.

Simple Home Peritoneal Dialysis Method Operable by Patient Without Medical Aid

Medical Tribune Report

New Medical Technology

PHILADELPHIA—A simplified home peritoneal dialysis system that can be operated by the patient with kidney failure without medical assistance after an initial period of instruction and that costs a fifth of the conventional cost has been developed here by Dr. Normal Lasker, a nephrologist at Thomas Jefferson University Hospital.

With the system, he explained, the patient attaches an automatic fluid cycler to a permanent catheter implanted in the abdomen and the process is completed while the patient sleeps.

There is no need, as in hemodialysis, to attach the mechanism to an artery or vein. Because of no direct connection to the circulation there is little danger of blood infection, Dr. Lasker pointed out.

The new device, he declared, is of lifesaving benefit to patients who physically or otherwise are not capable of using the standard method. These patients would include those with heart complications and those who have difficulty in learning complicated procedures.

The machine uses ready-made dialysis solution prepared at Jefferson by a new fluid manufacturing apparatus developed by Dr. Martin Roberts, of the Marquardt Corporation, California. The preparation and packaging of the solution in a hospital laboratory, instead of the need to purchase a commercial product, has led to the major cost saving, Dr. Roberts said.

So far, two patients have used the system successfully at home. While the project is in its initial stages, the machines are hand assembled by a chemical engineer, Bruce Jarrell, who is a third-year student at Jefferson Medical College.

Japanese Doctors Checked

Medical Tribune World Service
From Japanese Edition

OSAKA, JAPAN—Police are investigating the qualifications of all doctors in Osaka hospitals and clinics, following the arrest of two unlicensed practitioners and the director of the hospital in which they worked.

Complaints had been received from the relatives of 44 persons, including 18 children, who died after being treated by the two unlicensed practitioners.

The following briefs are from reports presented at the 73rd annual meeting of the American Society for Clinical Pharmacology and Therapeutics in Houston, Tex.

Inotropic Agent Effective

Evaluation of NC-7197 found it to be an orally effective, long-acting inotropic agent free from chronotropic activity and well tolerated in a single dose in men, investigators from the Washington, D.C., Veterans Administration Hospital and Georgetown University reported. The agent is 2-(3-ethylsulfinylpropyl)-1, 2, 3, 4-tetrahydroisoquinoline hydrochloride.

Fifteen normal volunteers received single oral doses of 100, 200, and 300 mg. Cardiac output increased insignificantly after 100 mg. but rose consistently by an average of 1.4 L. per minute after 200 mg. and by 3.2 L./minute after 300 mg. Cardiac output peaked at two hours but remained elevated for up to four hours after drug administration. Heart rate was not altered. Side effects were limited to nausea seen only at the highest dose level.

Authors were Drs. Bernardo Kotelanski, R. J. Groszmann, and Jay N. Cohn.

Drug Useful in Hypertension

In combination with such other agents as sympathetic blocking drugs, minoxidil, a new vasodilator with potent antihypertensive properties, appears "extremely" useful in patients with severe hypertension and renal failure, it was reported by Drs. Constantinos Limas, Nabil H. Guiha, and Edward D. Freis, of the VA Hospital, Washington, D.C.

The agent, U-10-858, 6-amino-1,2-dihydro-1-hydroxy-2-imino-4-piperidinopyrimidine, was given to seven patients undergoing chronic hemodialysis for end-stage renal disease. All had severe hypertension that could not be controlled by standard medications.

Minoxidil was initiated at 2.5 mg. twice daily and increased to 5 to 10 mg. twice daily, at which doses a satisfactory blood pressure response was obtained in all patients. They were maintained on prior drugs, but doses of the latter were decreased when the blood pressure stabilized at near-normal or normal levels with minoxidil.

Combination for High B.P.

A patient with moderately severe or severe hypertension not controlled by a diuretic would benefit equally from the addition of clonidine or methyldopa, it was suggested by a study reported by investigators from Georgetown University Medical Division and the D.C. General Hospital.

In 41 patients studied in a double-blind, randomized, crossover fashion, base-line (sitting) mean arterial blood pressure of 145 mm. Hg was decreased to 135 mm. Hg on chlorthalidone, to 121 mm. Hg on methyldopa-chlorthalidone, and to 117 mm. Hg on clonidine-chlorthalidone.

Authors were Drs. William Mroczek, Michael Davidov, and Frank Finnerty, Jr.

Pericardial Effusion

Medical management of malignant pericardial effusion offers considerable therapeutic benefit with less morbidity and expense than more aggressive surgical procedures, according to a team from Baylor College of Medicine.

Four patients with malignant pericardial disease who had predominant pericardial effusion rather than tumor encasement as the basis for tamponade received initial therapy with local instillation of a chemotherapeutic agent, with or without radiotherapy.

Of the three patients who made complete responses, two died two and 12 months after initial treatment, neither showing significant pericardial fluid at postmortem examination. One patient was alive and is asymptomatic after 29 months.

The authors were Drs. Frank B. Smith, Montague Lane, and Philip T. Hudgins.

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Vicious...Dangerous...Deadly

UNSUPPORTED INNUENDO, guilt by association, and character assassination were an unhappy, and many have thought a rejected, part of past American history. But once again, and this time in the field of health, we witness attacks addressing not issues and ideas but the men and the media that raise them. In politics, it is pernicious. In science, it is dangerous. In medicine, it can be deadly.

Political action on health can be constructive. Good social programs are indispensable for public health. They are essential for the encouragement of basic science and clinical research. On the other hand, political tactics can be destructive when they intervene in scientific debate and affect the rights of researchers and the responsibilities of physicians. They can be dangerous when they intrude into technical areas of research and therapeutics.

Unhappily, we may be witnessing the politicizing of the professional and technical areas of science and medicine. Even worse is the intrusion of the discredited tactics of innuendo, guilt by association, and character assassination into what should be the calm and considered province of science and medicine.

A scientist twice named a Nobel Laureate, Linus Pauling, raised challenging concepts related to the evolutionary changes in enzyme systems and the potential role of ascorbic acid. To address such issues by trying to tarnish the brilliance of one of the greatest minds in biochemistry, to avoid the facts and resort to calumny, with despicable whisperings of "senility," is to derogate scientific debate. Accusations of political heresy do not constitute a reasoned reply to the penetrating and provocative issues raised by such Nobel Laureates as George Wald and Salvador Luria. One cannot dismiss the human concerns of Nobel Laureate Norman Borlaug by slanderously implying that he is simply the tool of an agrochemical complex.

MEDICAL TRIBUNE, as an independent newspaper, has always been an open forum for dissenting points of view. It has not hesitated to tackle issues—whether popular or unpopular with either the right or the left. We do not believe that the medical establishment, as exemplified by the American Medical Association, or the medical left should be immune from criticism and comment. Nor does such immunity extend to academia, the pharmaceutical industry, the FDA, or other organs of government. Nor does such immunity extend to the press, whether lay or medical.

We believe that differences of opinion should be openly aired. We must examine, first and foremost, what is said and not just who says it. We are deeply concerned by the fundamental breach in what should be accepted practice in medical and scientific debate. It is no less a matter of concern when the use of innuendo, guilt by association, and character assassination are the resort of the liberals and the left, of the counterculture, or of crusaders. Such means can never be justified; they invariably pollute and ultimately destroy the ends sought.

A.M.S.

Pity the Poor Dean

SOME YEARS AGO, a medical school dean welcomed the incoming freshman class with the consoling remark that the mortality of deans exceeded that of medical students, which shortly proved true in his own case. Today the disparity is even greater. Almost all medical students go on to attain their degrees. The casualties among deans are greater than ever. The dean's half life—i.e., his decay rate—now averages just three years.

Assailed by burgeoning expenses, stringently curtailed budgets, cuts in Government research funds, demands to increase student enrollment while condensing four years into three, and a variety of other pressures, medical school administrators may need advice. But the advice that is continuously and gratuitously offered may not always be, as students say, "relevant" to their problems. An illustration of well-intentioned proposals appears in the March, 1972, issue of *Family Physician*, the organ of the American Academy of Family Physicians. Drs. Mark G. Field and J. Gershon-Cohen propose: *"The modern clinician must be thoroughly trained in iatric detection, clinical staging, clustering, sequencing and careful notation of duration and extent of morbidity as vital factors in human illness. . . . Clinicians will employ the new mathematics: symbolic logic, set theory and Boolean algebra. Unquestionably, this is the course the training of future family doctors must take."*

We had enough difficulties with Gray's *Anatomy* and what followed for four years; we shudder at what awaits the coming generation. But we still think the best preparation for a medical-scientific career is what was said of the ecologist Rachel Carson by David Brower, "She did her homework . . . and she cared." The essence of the physician's *vade mecum* is scholarship, clarity, and compassion—boolean algebra or no.

R.S.G.

Panendoscopy in Upper GI Hemorrhage

CLINICAL QUOTE: *"In 41 patients with acute upper GI bleeding, the probable source was documented by panendoscopy in every case. . . . We feel that with vigorous ice saline lavage, an experienced and tenacious endoscopist can expect to document the bleeding in perhaps 90 to 95 per cent of cases."* (Drs. Ronald M. Katon and Frederick W. Smith, University of Oregon Medical School and Veterans Administration Hospital, Portland, at the Western Section, American Federation for Clinical Research; see page 3.)

"Do I know anything about get-well cards? Madame, I'll have you know I had two years of premed!"

LETTERS TO TRIBUNE

Theophylline Therapy

Editor, MEDICAL TRIBUNE:

Round-the-clock high-dosage theophylline therapy in treatment of asthmatic children, as reported by Dr. M. W. Weinberger in MEDICAL TRIBUNE of March 8 is, in my opinion, a highly hazardous method of treatment.

That high blood level of theophylline is necessary for relief of bronchospasm is indeed true. However, maintenance of such levels for any period of time may well again produce an epidemic of aminophylline poisoning, as reported all too frequently in the early days of the use of this drug.[1,2,3] I would ask Dr. Weinberger, would he advocate giving asthmatics or even normal children the equivalent of 20 to 30 cups of strong tea or coffee daily and that without the water we drink with these beverages?

J. J. ROBBINS, M.D.
Hayward, Calif.

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2. Love, F. M., and Corrado, A. L.: "Aminophylline Overdosage in Children," *Amer. J. Dis. Child., 89:468, 1955.*
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■

'Negative Medicine'

Editor, MEDICAL TRIBUNE:

The editorial comment entitled "The Malpractice Threat," that appeared in the March 22 issue, had for its concluding sentence: "The flaws in the investigation ought to be pinpointed and efforts made by others for a more definitive examination of 'defensive medicine' and its effects on the costs of medical care."

This rhetorical question can be answered quite succinctly with the statement that defensive medicine is practiced and does increase the costs of medical care. Any research investigator on this subject will find that physicians and surgeons call in more consultants than ever before even when the answer raised for the consultant is already known by the attending physician or surgeon requesting the opinion. This rise in consultations is especially noticeable in those hospitals where the visiting staff has had many lawsuits based upon negligence. Multiple consultations are encouraged not only by the rules and regulations of the individual hospital but also by the requirements of the Joint Commission on the Accreditation of Hospitals and the legal advisers to the insurance carriers insuring hospitals, physicians, and surgeons against professional negligence.

When multiple consultations are the order of the day, delay in treatment results because almost every consultation will conclude that additional studies (x-rays or laboratory procedures) should be performed. Such recommendations not only prolong in-hospital stay but increase x-ray and laboratory costs. One must conclude that doctors of medicine at the present time are practicing "positive defensive medicine." This tendency will be increased intensively unless some relief from the threat of malpractice actions is given to the medical profession.

The comment on "negative defensive medicine" should be elaborated upon with more emphasis. As defined in the *Duke Law Journal*, negative defensive medicine is the "refusal to undertake activities which have a high risk of resulting in malpractice litigation." More specifically it can be stated that physicians and surgeons who have been sued for imputed negligence associated with or due to a certain procedure will hesitate to perform that procedure or will abandon it entirely by referring the patient elsewhere. For example, a general practitioner who has had an experience of performing more than 400 tonsillectomies during his professional lifetime will no longer accept patients for tonsillectomy following two malpractice actions against him. The first sad experience concerned an eight-year-old girl who had a laryngeal spasm necessitating an emergency tracheotomy. The child survived, but a residual hoarseness persisted secondary to trauma to the vocal cords. This hoarseness was the basis for a cause of legal action which involved the attending physician, the hospital, and the anesthesiologist. The second maloccurrence was similar, with cerebral anoxia and residual brain damage. This doctor of medicine no longer performs tonsillectomies and frankly admits he is afraid to undertake them.

Another situation in point concerns a fine orthopedic surgeon who has three distinct malpractice actions against him founded upon surgical treatment of three different patients with intervertebral disk syndromes whose end results did not measure up to the anticipated expectations. This excellent surgeon no longer accepts disk syndrome patients either for consultation or treatment.

The opinions expressed in this letter to the editor are based upon more than 100 experiences in the preparation of legal defenses in malpractice actions against doctors of medicine who have been sued in the states of New York, New Jersey, Pennsylvania, Kansas, Illinois, and California.

BERNARD J. FICARRA, M.D., Sc.D., LL.D.
Oyster Bay, L.I., N.Y.

San Francisco Center Focusing on Causes of Cancer

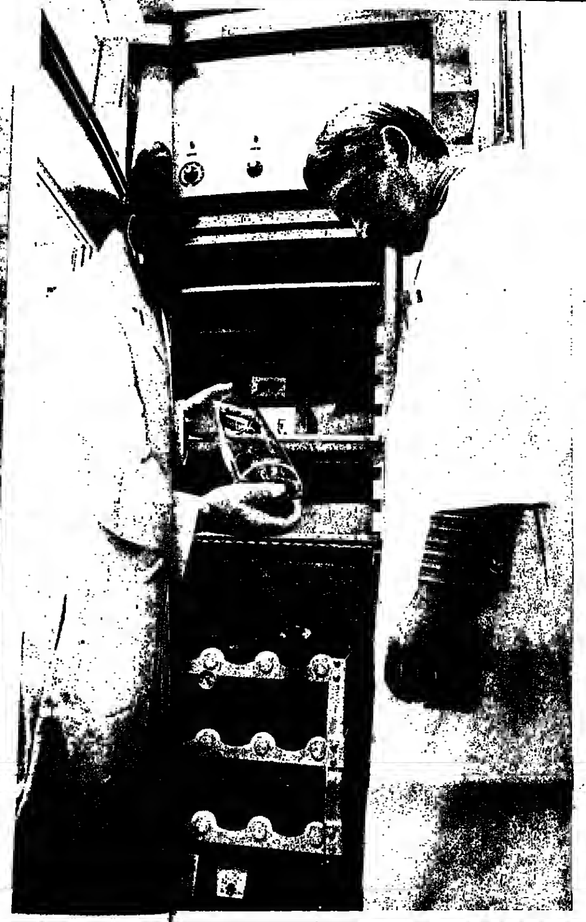
COUPLING RESEARCH, diagnosis, and treatment, the recently formed Division of Clinical Immunology, headed by Dr. Ernest Rosenbaum, at Mount Zion Hospital and Medical Center in San Francisco, initially focuses on elucidating the causes of cancer and applying the data in experimental treatment. The researchers, drawn from both Mount Zion and the Department of Hematology and Immunology at the University of California, San Francisco, have been conducting comparative studies between the immune competence of cancer patients and the normal population and investigations to identify and isolate tumor-specific antigens.

The cooperative arrangement extends to other departments. For example, with assistance from the surgical service, various human cancer specimens are being acquired for establishing a "tumor farm."

The division also runs a continuing education program, consisting of a series of lectures on basic immunology.

In laboratory, above, is researcher Dr. H. Hugh Fudenberg, who is director of the Department of Hematology and Immunology, University of California, San Francisco. Dr. Fudenberg has received the Posteur Medal, among other awards. Below, Dr. Myron Blume (l.) and Dr. Rosenbaum inspect lymphocytes in cultures.

Human breast tumor growing in culture from "tumor farm," above. Dr. Joseph Wybran (l.) and technician Richard Miner check incubator with roller apparatus for large-scale culture growth, right.



Drawings, Paintings Found to Mirror The Experiences of Disturbed Children

THE THERAPEUTIC VALUE of drawing and painting is emphasized in the children and youth section at the St. Gorans Clinic in Stockholm. The patient's work often starkly mirrors their experiences: one 13-year-old girl, who was disfigured in an accident, drew pictures of children whose faces were dark and without details. A 10-year-old boy with symptoms of childhood psychosis made a bloody, long-nailed, threatening hand. He revealed, "The hand will draw me at night."

Figure, left, with disproportional ears was painted by a mentally retarded girl with a hearing defect. Food motifs represented by a grocer's cart, a café, and a foodstuff vendor appear in picture that was drawn by a child with anorexia nervosa.

Transportation Seen Crucial to Disabled

TRANSPORTATION should receive top priority as a problem of the handicapped, Dr. Henry Betts, medical director of the Rehabilitation Institute of Chicago, told a meeting of 40 state driving licensing administrators. Reduced mobility narrows the chances for an education, job, and socializing, he continued. Afterwards, disabled drivers demonstrated hand controls and other devices.

As part of conference, engineer Joseph Ivko shows adaptive instrument for driving that he invented. Mr. Ivko lost both of his arms in an electricity accident.

Caring: A satellite community Day Care Center for Mentally Retarded Children is being operated in Philadelphia by the Albert Einstein Medical Center. The classes, according to age and degree of mental retardation, prepare children for admission to public schools or, in more severe cases, provide self-help skills so the children might function in vocation programs, explained director Peter Bodenheimer.

Youngster, one of 40, laughs while inside "time tunnel" cocoon.

'MD School Without Walls' to Open in Maine

Medical Tribune Report

PORTLAND, ME.—Among the medical schools now proposed or under development is one that seeks on funds for bricks and mortar.

The "medical school without walls," as the College of Physicians of the University of Maine is conceived, asks no construction money because it will operate entirely in existing facilities at universities, colleges, and hospitals in the state. Its teaching will be conducted, for the most part, by faculty and staff already at those institutions.

Outside interest in plans for the Maine school, which is aiming at admission of the first class in 1973, is also being generated by plans to emphasize the training of family practitioners for medical teams delivering care in rural areas.

Dr. Cope Appointed

Dr. Oliver Cope, Emeritus Professor of Surgery at Harvard Medical School and senior consultant surgeon at the Massachusetts General Hospital, has been appointed Special Assistant to the Chancellor of the University of Maine for Medical Education. Dr. Cope, on leave of absence from his Boston positions to aid in developing the Maine school, will establish clinical arrangements and develop curriculum details.

Plans for the school without walls call for mini-campuses, eventually five in number, each at a state university or quality private college and a hospital with 300 or more beds. One of these campuses will be the student's base for the first two years of a three-year program. The third year will be spent in preceptorships in small hospitals, medical groups, clinics, and community health centers, where the student also will work with a variety of allied health professionals.

As they progress through the problem-oriented curriculum, students will have considerable exposure to computerized self-learning programs. Some teaching will be by two-way interactive television with data transmission, although direct patient contacts, beginning the first semester, will go along with it wherever possible.

The school's planners believe that working out the best ways to use TV and other technology in medical education will have a spinoff in improved medical care delivery through innovations that can help the isolated family practitioner.

Appropriate Material Available

The question of adequacy of clinical material is bound to arise when a sparsely populated state begins medical education, and this was covered in the Maine feasibility study. The survey indicated that appropriate material is available 80 per cent of the time.

A flexible curriculum will allow for taking advantage of rarer material as it appears and no one is deterred by the probable necessity of some shuttling up and down Interstate 95—which connects all the mini-campus sites—to bring students together with specialists and their patients.

Anticipated size of the first class is 24 students. The entering class is expected to number 36 the following year and eventually to reach 60. Qualified students will be accepted after three undergraduate years.

Admission standards have not yet been set, but in seeking students likely to be attracted by family practice, the Maine College of Physicians may go beyond traditional academic standards and interviews. Under discussion is the use of one or more personality or vocational interest assays that would indicate flexibility and social motivation.

Another departure in the Maine plans is the absence of department chairmen. The report presenting the plan to the university trustees stated, "Medical schools whose faculties consist entirely of specialists graduate few students who become generalists." The search committees will be looking for "respected, community-oriented, broad-based, primary-care physicians," each to be a "coordinator of learning activities" for 12 students.

These coordinators will each be responsible for planning instruction in a portion of the academic curriculum and for student evaluation in the particular area.

Aside from the organizational complexities of getting the medical school under way, medical educators here face some problems not familiar to schools in wealthier, more populous states. There is no faculty on the proposed mini-campuses to teach two preclinical subjects and a few of the clinical subspecialties. There are only two hospitals in the state with house staff training programs, although development of two or three more is being encouraged and aided.

Also, some of the state's physicians have yet to be won over to the plans for the school, although the House of Delegates of the Maine Medical Association and the state chapter of the American Academy of Family Physicians are solidly behind it.

Physicians Increased by Only 25

But the need for increased medical services, particularly in remote areas, is recognized at all levels of government and medicine. Some counties in Maine have physician-population ratios of one to 1,700-1,900, and the total number of physicians in the state increased by only 25 during the decade 1960-70. A medical school in the state may not be the only way to better this situation, but educators and health professionals point to the experience of other states showing that it helps.

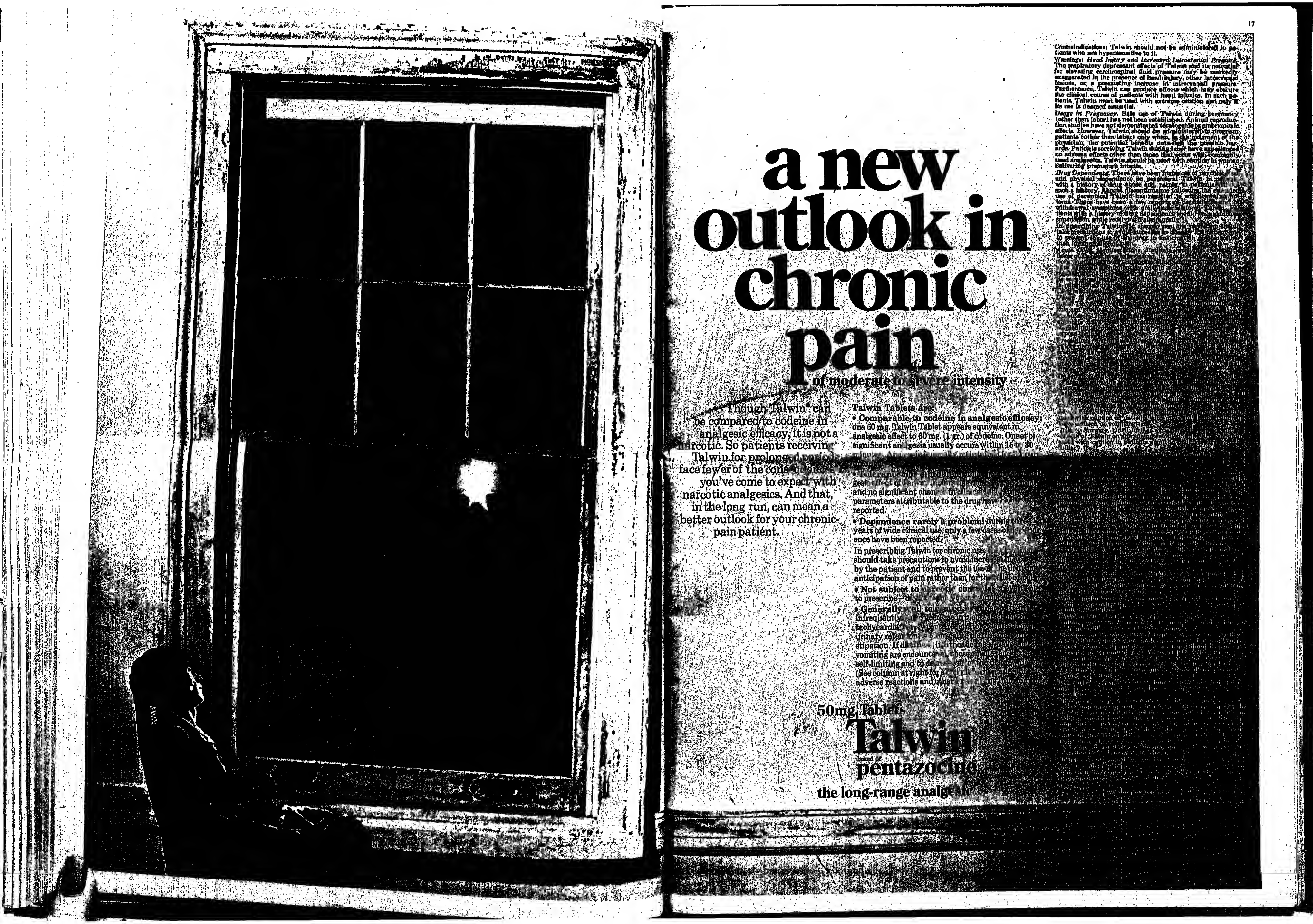
If the medical school without walls succeeds in this goal, they observe, other areas with similar problems will have its experience to build on.

Organizing the clinical arrangements and curricular details for the new medical school will be the task of Dr. Oliver Cope.

30 Scientists Added to Those Receiving Heart Group Support

NEW YORK—The American Heart Association announced today that 30 more scientists had been selected to receive long-term support for the year starting July 1, when a record $16,000,000 is expected to be spent on research in heart and blood vessel diseases.

The 30 scientists named as established investigators join a prior group of 97 men and women of that rank receiving five-year awards and 14 others with the rank of career investigator, who receive lifetime support.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of moderate to severe intensity
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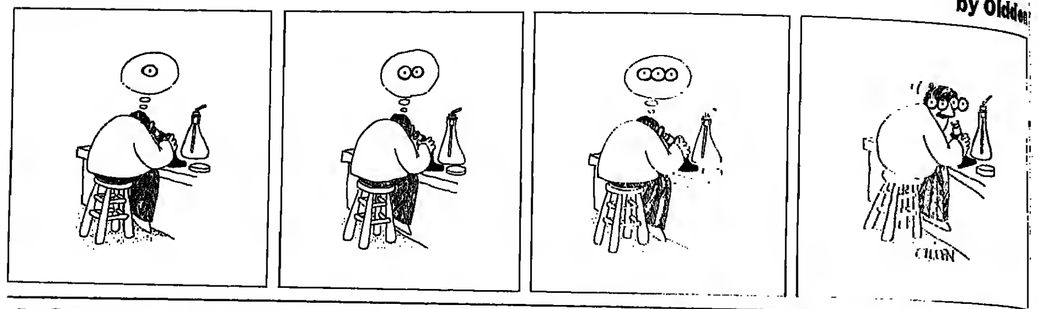
Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.
Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms.



A Simple Office Procedure May Spark Malpractice Suit

Continued from page 1

are going to do and make sure that at least one parent is present."

His warning struck a responsive chord in the audience.

One physician arose from the floor to offer this advice: "If you've got a rebellious child on your hands and he won't hold still, don't try to do any office surgery until the parent comes to the room and holds the child. Insist on that. Otherwise you may have an unpleasant incident on your hands."

Another physician described a lawsuit that followed when phenol was used as a local anesthetic in treating an ingrown toenail in a 16-year-old girl. The phenol penetrated to the bone and produced local injury.

This prompted a third physician to ask the audience: "How many here have written consent forms in the office?"

A few hands were raised. And there was a general sense that a door had been left unlocked.

From ingrown toenails and sebaceous cysts, as well as dorsal ganglia, the discussion moved to vasectomies—and their potential legal problems. There emerged agreement that the operation must be preceded by full and detailed explanation to both the husband and wife, that consent must be obtained in writing, and that the patient and his spouse must understand that the surgery is, for all practical purposes, irreversible.

DR. DAVIS

Panelist Dr. Thad Mosely, Associate Clinical Professor of Surgery, University of Florida, noted that the urologist in his group practice team performs the operation. But the group, he said, has adopted the policy of "insisting that the consent form for vasectomies not only be signed but notarized."

"With vasectomies becoming so common," said a physician from the floor, "we not only insist on informed consent, we make sure that the problems and risks are all down in writing, fully detailed, and that the patient knows exactly what he is signing."

Dr. Davis noted that North Carolina state law requires the written permission of both the patient and his wife; then calls for a 30-day "cooling off period." He added that, in addition, he requires the husband and wife to re-sign at the end of the 30-day period.

Panel chairman Dr. William C. Cantey, of Columbia, S.C., chief of surgical service at Columbia Hospital, commented that the practice in his service is to insist on a six-to-eight-week wait after the couple have agreed to the vasectomy.

What about the medical-legal safeguards required in treating mammary fluid cysts? the panel asked. Dr. Mosely inquired how many of those present aspirated a fluid cyst from the breast. A forest of hands went up. How many, he then asked, send the fluid off for a laboratory report? There were no hands.

Sends Fluid to Laboratory

"It is important," he stressed, "to send fluid from these cysts to a laboratory for study.

"The results will probably be negative, as we know. But it is very reassuring to the patient, and it is an important protection against future lawsuits. No one can come back at you and say that you failed to make the proper studies."

But a physician from the floor arose to offer another precaution: "I have yet to see a breast with a single fluid cyst," he commented. "You stick your head into a medicolegal noose if you send the patient on the way, feeling her problem has been dealt with, and six to eight months later she shows up with a malignancy."

This prompted separate retorts from two of the panelists.

Dr. Mosely: "I would agree that no breast has just a single mass. But you can't just operate in every case."

And Dr. Davis: "Of course, these are patients in a high-risk group. We follow them every six months with mammography. But, frankly, I think it's malpractice to excise every cyst you see in a breast!"

Ultrasonography Shows Polycystic Kidneys

Ultrasonic scan of the kidney area in patient with polycystic kidney disease. The technique can assist in the proper placement of the biopsy needle, and may be useful in deciding on renal biopsy by detecting cystic lesions, says Dr. Joseph H. Holmes.

Technique Reported To Give Broad Data In Kidney Pathology

Continued from page 1

to rule out the presence of cystic lesions, which would be a contraindication to performing renal biopsy, he added.

The transplanted kidney, because of its location in the groin close to the surface, is easily visualized with ultrasound, he told the meeting. Changes in renal size indicated by ultrasonography can be helpful in assessing complications during long-term follow-up of transplant patients, he said.

Ultrasound has also been of value in giving additional diagnostic information on hydronephrosis and renal stones and in assessment of associated intra-abdominal and cardiac abnormalities in patients with renal disease.

Studies of the bladder with ultrasound have also proved useful in a variety of situations, including the demonstration of distortion of bladder contour by adjacent pathology, irregularities of bladder wall produced by chronic infection, and presence of tumors, stones, and foreign bodies within the bladder, Dr. Holmes said.

Because of scanning limitations, the definition is not sufficient to produce a precise outline of a foreign body or stone or a precise description of the nature of the tumor, he remarked, but the studies do provide good screening information that assists in the programming of further diagnostic evaluation.

Routine Atropine May Harm Infarct Patients

Medical Tribune Report

CHICAGO—The routine administration of atropine, proposed as a protective maneuver in acute myocardial infarction, may actually be life-threatening, according to experimental studies reported here at the 21st annual scientific session of the American College of Cardiology.

Approximately 50 per cent of sudden deaths secondary to acute myocardial infarction (AMI) occur within two hours after onset of the symptoms and most of these deaths are due to ventricular fibrillation, noted Dr. Richard B. Karsh, pediatric cardiologist of the cardiology branch of the National Heart and Lung Institute. Since increased heart rate suppresses some ventricular arrhythmias, he said, self-administration of atropine at onset of AMI has been advocated as a measure to reduce AMI mortality.

To test this hypothesis, Dr. Karsh and colleagues produced AMI in 55 conscious closed-chest dogs by inflation of a balloon cuff previously implanted around the left anterior descending coronary artery. Ten minutes after occlusion, 28 of the dogs were treated with atropine, maintaining heart beat between 90 and 120 per minute. After an hour, occlusion was released for 10 minutes and "release arrhythmias" recorded. The coronary artery was then re-occluded two more hours.

While the mean heart rate after 10 minutes of occlusion rose from 69 to 81 for the controls and from 71 to 88 for the treated dogs, "the difference in rates between the groups was not statistically significant," Dr. Karsh reported. At one hour of occlusion, however, the heart rates of the control group had returned to preocclusion levels while those of the treatment group rose significantly after atropine.

Bradycardia Seen in First Hour

"Of interest," he said, "12 of 27 control dogs, an incidence of 44 per cent, developed bradycardia during the first hour of acute coronary occlusion. However, in contrast to commonly held beliefs, the incidence of ventricular arrhythmias was lower in these bradycardic dogs than in the dogs with higher rates during occlusion."

Two of the 12 dogs with bradycardia, he reported, remained arrhythmia-free during occlusion and none developed malignant arrhythmias (ventricular arrhythmias with R-PVC intervals less than 0.43 second). On the other hand, only four of 15 nonbradycardic dogs remained arrhythmia-free during occlusion and seven developed malignant arrhythmias.

This experimental model indicates, Dr. Karsh said, that bradycardia does not predispose to ventricular arrhythmias.

In analyzing the effects of atropine, a consistent trend was evident, he said. Atropine "never protected against the development of arrhythmias, and in several instances it increased their incidence significantly."

Thus, 52 per cent of the control dogs had no arrhythmias during coronary occlusion compared to only 7 per cent of the atropine-treated animals.

Furthermore, while only 30 per cent of the controls developed malignant occlusion arrhythmias, 57 per cent of the atropine-treated dogs did so. Of 16 dogs that developed ventricular fibrillation, 11 were in the atropine group.

It was concluded that slow heart rates following experimental AMI are associated with a decreased risk of developing arrhythmias and sudden death than higher rates, and that atropine tends to increase the incidence of arrhythmias during AMI.

Coauthors were Michael Orlando, Ph.D., Douglas Norman, and Dr. Stephen E. Epstein.

Correction

The report of a study of survival of patients with potentially fatal arrhythmias, published in the March 8 issue, incorrectly attributed the investigation to researchers at Jewish Hospital, Cleveland. The investigators were from the Jewish Hospital, Cincinnati.

IUD Containing Progesterone Backed by a Study of 109

Continued from page 1

Population Council, Rockefeller University, New York, was used as the vehicle for the progesterone capsule.

"This small T-shaped polyethylene I.U.D. has been reported to have a low expulsion rate and negligible removal rate for bleeding and pain," Dr. Scommegna said.

Vertical Arm Cut Off

The progesterone T was constructed by cutting off the vertical arm of the plain T 3 mm. below its insertion to the horizontal branch and substituting the progesterone capsule. A 30-mm. length of Silastic medical-grade tubing with an outside diameter of 3.18 mm. was used to make the capsule. It was filled with milled crystals of progesterone and attached to the plastic T. Insertion was accomplished with a plastic straw type of introducer.

The in vitro progesterone diffusion rate decreased exponentially with time, Dr. Scommagna noted. It released about 400 micrograms of progesterone per 24 hours the first week, 200 by the 14th day, 160 on the 60th day, and about 100 by the 120th day.

"After the capsule had been in the uterus for six months it contained 6 mg. of progestarone and released about 60 micrograms of progestarone per 24 hours," he said.

The patients were studied for a total of 331 women-months.

"No patients conceived while an intact progesterone device was in situ," Dr. Scommegna said. "Two pregnancies occurred when the progesterone T action was deficient."

Dr. Scommagna reported that one patiant was found to be six weeks' pregnant after five months from the time of insertion. Removal of the device revealed that the progesterone had leaked out because of a defect in the capsule. The other pregnant patient was found to have 1 cm. of the capsule extending outside the external os and aborted a few days after removal of the device.

"There were another five patients with a similar partial expulsion who were not pregnant," Dr. Scommegna said.

Two patients expelled the device completely. Five devices were removed—two because of pain or bleeding, one for acute pelvic inflammatory disease, and two for personal reasons.

Noting that at least five pregnancies were statistically feasible in 331 women-months with a plain T, Dr. Scommegna said the no-pregnancy result demonstrated that the progesterone "contributes significantly to the contraceptive effectiveness of an intrauterine device."

An endometrial biopsy performed after six to seven months in nine patients after removal of the progesterone I.U.D. showed "suppressed" endometrium in all cases.

Contraceptives Less Dangerous Than Lack of Protection

From London

► Of all methods of birth control, only low-dose progesterones and sterilization are safer than full-estrogen oral contraceptives, according to Dr. D. F. Hawkins, senior lecturer, Institute of Obstetrics and Gynecology, Hammersmith Hospital, London.

"The consequences of unprotected intercourse are 10 times more lethal than those of oral contraceptives, and legal abortion as a method of family planning is more dangerous still," he said.

Dr. Hawkins reported that in a carefully drawn up survey based on estimates of mortality associated with contraception, combined oral contraceptives with 20,000 pregnancies per million users per year, resulted in five deaths related to pregnancy and 20 related to the method.

The survey also found that in 60,000 pregnancies with low-dose progesterones, there were an estimated 15 deaths related to pregnancy and none due to the method.

Intrauterine devices, with 40,000 pregnancies per million users per year, resulted in 10 deaths related to pregnancy and 20 to the method.

In the case of condoms and diaphragms, there were 150,000 pregnancies per million users, with 33 deaths related to pregnancy.

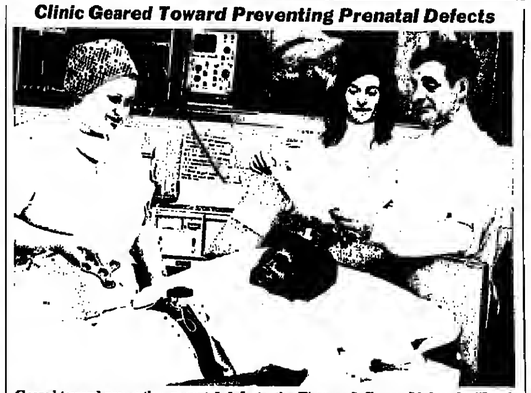
Spermicides and withdrawal, associated with an estimated 250,000 pregnancies per million users per year, resulted in 56 deaths related to pregnancy.

Sterilization, male or female, associated with 1,000 pregnancies per million users, resulted in 15 deaths related to the method.

Unprotected intercourse was responsible for 800,000 pregnancies per million users, with 220 deaths during pregnancy.

In legal abortions in hospitals there were 310 deaths. Dr. Hawkins commented: **"If development proceeds in the field of low-dose oral progesterone contraception, and drugs and doses with a lower pregnancy rate can be evolved, it seems likely that this method of contraception will become the safest of all."**

Clinic Geared Toward Preventing Prenatal Defects



Geared toward preventing prenatal defects, the Thomas Jefferson University Hospital high-risk antenatal clinic continuously monitors its maternity patients. Above, Dr. Martin Wingata, Lydia Wingato (c.), and Janette Blumberg, R.N., watch fetal heart beat and maternal uterine contractions and electromyographic data.

Tumor Kept Dormant in Vivo By Denying Its Blood Supply

Continued from page 1

the size limit at which that tumor can survive with only the process of diffusion supplying nutrients and disposing of catabolites. In actuality, the innermost cells of the tumor are dying while mitosis is accomplished by the outermost cells—a combined action that makes the tumor appear to oscillate slightly in time-lapse cinemicrography, Dr. Folkman said.

Although "dormant" in a sense, the tumor is putting out TAF. The investigators can detect it in the medium of the eye chamber. So can the nearest capillaries, which bud and proliferate all over the iris "looking for the tumor," as Dr. Folkman put it, but unable to respond directionally and find it. (If the tumor is allowed to drop to the iris, it picks up capillaries, grows 4,000-fold in eight days, and bursts through the eye.)

In a less isolated site, as the Boston investigators have shown in many organ perfusion chamber experiments, the tumor puts out TAF and, only six hours later, capillary endothelial cells within 3 mm. of it begin to synthesize DNA. By 24 hours new capillary sprouts have appeared and begin to grow toward the tumor at a rate of 1 mm. per day.

TAF, which Dr. Folkman and co-workers isolated in 1970, is apparently unique to solid tumors. It is not found in leukemia, or in normal tissue, or in regenerating tissue, such as liver. TAF also is unique in its target specificity; it is mitogenic only to capillary endothelial cells.

In one troublesome way, however, TAF is very nonspecific. As far as can be told, it is the same RNA and protein complex of about 100,000 molecular weight whether it comes from a human, rabbit, rat or other solid tumor. Which means that human TAF cannot be injected into a rabbit to produce antihuman TAF. That has been done, Dr. Folkman said, and the rabbit simply "grows a lot of new capillaries." Such growth is limited to the injection site; TAF is destroyed in circulating plasma, probably by ribonuclease.

Regress if TAF Is Withdrawn

Capillaries elicited by TAF regress when TAF is withdrawn. The investigators find that in the absence of continuous TAF stimulation the capillaries begin to disappear in three to four days. This property alone suggests that large tumors might be made to regress to dormant size if an anti-TAF were available. Dr. Folkman envisions other uses of antiangiogenesis in concert with radiotherapy, chemotherapy, or immunotherapy as well as following surgery for removal of a primary tumor.

The Boston group already is at work trying to produce an antibody to TAF, according to Dr. Folkman, who says, "You can make an antibody against anything, given enough money." The work is proceeding on the conjecture that hemocyanin or a hapten can make TAF antigenic.

The idea of keeping tumors dormant through antiangiogenesis is not wholly unphysiologic, Dr. Folkman said. He sees possible examples in such instances as the metastases that remain small in lungs of children who had thyroid primary tumors.

Given an anti-TAF agent, the malignancies most appropriate for treatment with it would be the most vascular-dependent, such as brain tumors, while the least appropriate might be something like a chondrosarcoma, which is nearly avascular.

Co-workers on the angiogenesis projects include Drs. Michael Gimbrone, Mark Hochberg, and Stephen Leapman.

Brown U. Will Expand

PROVIDENCE, R.I.—The Corporation of Brown University has voted approval for expansion of the Brown medical program to a full-fledged M.D. degree program, provided adequate financing can be found, including a financial commitment from the State of Rhode Island.

Librium® dosage options: as versatile as anxiety problems are varied
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Librium has demonstrated its effectiveness in relieving clinically significant anxiety associated with a wide range of emotional and somatic problems.

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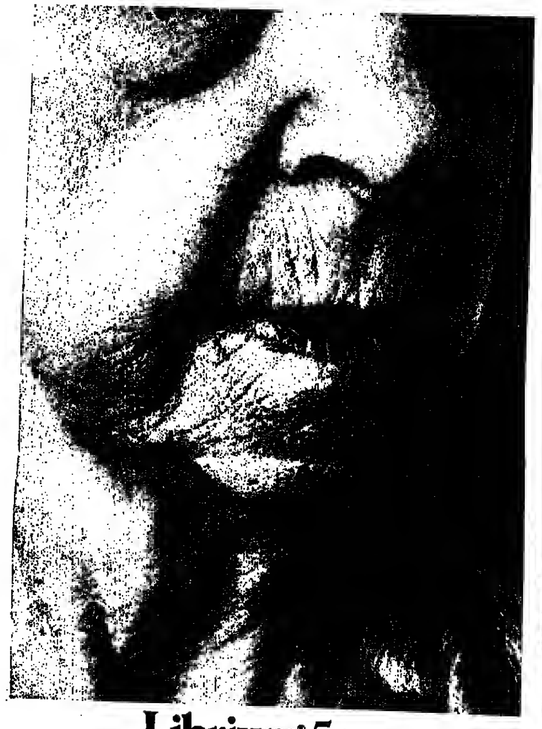

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Librium, because of its wide margin of safety, is especially well suited for extended use until the patient can perform at appropriate levels without it. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.) Moreover, the antianxiety benefits of Librium are generally maintained without diminution of effect or need for increase in dosage. When treatment is prolonged, periodic blood counts and liver function tests are advisable until antianxiety medication is no longer required.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions:

ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Supplied: Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Ampuls containing 100 mg chlordiazepoxide HCl.

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AstroTurf Said Not to Lower Leg Injury in School Football

Medical Tribune Report

NEW ORLEANS—A four-season study of football injuries sustained by the Seattle Metro League, consisting of 14 teams of high school players, does not indicate that playing on an AstroTurf field reduces the incidence of knee and ankle injuries, according to Dr. Harry H. Kretzler, Jr., of Seattle.

During the four seasons, the teams played 176 games on the artificial turf and 47 on grass fields, he told the 13th National Conference on the Medical Aspects of Sports here, sponsored by the American Medical Association.

DR. KRETZLER

The incidence of knee injuries on AstroTurf was 0.312 per game and on grass 0.298, he reported. The figures for ankle injuries were 0.170 and 0.149, respectively.

"Considering the small numbers and possible inaccuracies of reporting," Dr. Kretzler observed, "there is little or no difference in the two fields."

The study revealed that 36 per cent of the knee injuries that occurred on AstroTurf and 14 per cent of those that occurred on grass went to surgery—a finding that "makes one wonder if the injuries are not more severe when they do occur on AstroTurf."

In a further comment, however, Dr. Kretzler stated that one cannot "unequivocally" say that surgery is an indication of a more severe injury. Perhaps, he reflected, a higher surgery rate is rather an indication of the fact that certain leading orthopedic surgeons have convinced their colleagues that early repair gives a better end result than late reconstruction. "Perhaps," he added, "surgery is better accepted now, by both the player and the physician."

Dr. Kretzler also reported "an general impression" that there was a smaller incidence of injuries on wet AstroTurf than on dry, but he pointed out that the difference had no real significance and that furthermore what constituted a wet or dry turf was not clear-cut.

Discussing "natural turf," he remarked "there may be more variation between different types of grass fields than between grass and artificial surfaces."

The grass field, he noted, may be lush and green, perfectly maintained, and used a limited number of times a year. Or it may be a sunbaked, primarily dirt field with rocks and holes, or a soft, boggy grass field easily turned to mud with any rain or heavy usage, or one initially frozen in the last part of the season.

The grass field used by the Metro League, he said, is soft, often muddy, with divots frequently taken and holes not uncommon. He could not say, he declared, whether this is a dangerous or safe field, "but I do know that abrasions on this field are rare indeed."

One of First Installed

The artificial field used was one of the first outdoor fields installed, with considerably less padding than is currently being used.

Determination of whether a field is wet or dry is not easy, Dr. Kretzler observed, since frequently, due to irregular water runoff, there may be patches of wet and areas of dry. Did the injury occur in the wet area or the dry, and what is wet? he asked.

"Our injury reporting," he pointed out, "is certainly not sophisticated enough to suggest accuracy in this regard."

Abrasions, he declared, are a special problem on artificial surfaces.

"This is the only injury that our coaches felt was related to the surface itself," he said, adding, however, that a sunbaked dirt field has problems with abrasions also.

He suggested that better protective clothing and padding should be able to lessen this problem and that wetting the field might also help.

Dr. Kretzler pointed out that there have been many improvements in the newer installations of artificial fields, mainly in the padding under the turf, which achieves a softer surface that is easier on the player when he falls.

Replying to suggestions that there be a moratorium on the installation of artificial surfaces, Dr. Kretzler said: "I know of no evidence to make such a move reasonable....Neither do I believe there is any evidence that their surfaces create any problems that didn't already exist in football."

He said he is unable to state whether there has been an increase in football injuries recently. If there has, he said, it would be because players today are bigger and faster and hit with greater impact.

"This in itself would be reason enough to expect more injuries. Colliding is the name of the game. If an artificial surface seems to accentuate this, I would tend to blame the game, not the surface....Perhaps a few rule changes would be important."

Shotputter Gets the Eye

Wide World Photo

Practicing under the watchful eye of coach Dr. Harmon Brown is Maren Seidler, 20, the national indoor shotput record holder. Dr. Brown hails from the VA Hospital, Livermore, Calif., where he is the chief of medical services.

Now Hear This!

We've just learned from the *Wall Street Journal* that various sources are successfully supplying Sunday sermons to men in the pulpits.

One outfit, Liturgy Publications, is reported as supplying 52 "bland" sermons a year's supply without a controversial word to over 5,000 subscribers for a $25 fee. You can also get two taped sermons for only $3.95 from, of all people, Red Barber, the former sportscaster.

The thought of dozens of clergymen throughout the country delivering the same words of wisdom and comfort at approximately the same time on any given Sunday can give one pause, as can the prospect, if one is a traveling churchgoer, of hearing the same sermon, Sunday after Sunday, from different mouths in different places. The next step, presumably, will be replacing the clergyman entirely with a tape recorder, microphone, and good public address system.

Matter of fact, why doesn't somebody sell taped medical meetings? The meeting need never be actually held; nobody would have to go [the hotels and airlines might object, but we're not going to let them run our lives]; and all sorts of options would be open to the physician in the privacy of his home.

He wouldn't have to listen to dull papers A and B in order to hear brilliant paper C. He wouldn't have to rush from Dr. X's report in the Beowulf Room at 10:30 to Dr. Y's at 10:50 in the Faerie Queen Room (down 11 flights in an East flank elevator, across the mile wide lobby to the Ballroom elevator, up to the third floor, along a fire corridor in just past the La Belle Dame Sans Merci Suite). He could endlessly replay one paper until he found out what the chap with the peculiar Austrian accent really did say.

Or he could buy the tape and not listen to it at all. He could just leave it boldly labeled container lying around his waiting room as evidence of his intention to Keep Up.

• • •

In San Francisco, according to United Press International, the Teamsters Union now includes coverage for acupuncture in its medical insurance.

• • •

We've recently encountered two bridges, an inevitable one and a better one, and share them with you to help you with your traveling.

• "The inevitable bridge between good health care and poverty's numerous social side effects is being crossed by nursing students at the University of Illinois Medical Center Campus in Chicago and the nearby St. Francis Xavier Cabrini Community Health Center."
—release from the University of Illinois.

• "This writer believes the Division of Health and Physical Education of the New York State Department of Education took the best possible action open to it at the time and that, rather than condemning the action, we should make every effort to use the evidence gathered to build a better bridge to tomorrow. The data gathered provide us with a good approach to the bridge; let us use it to build a sturdy, lofty structure over the rapids below instead of a foot bridge that will be unpassable in the spring flood. To carry the analogy one step further let us use the evidence available to us as an alternate route—a by-pass that will allow the traffic to continue to flow until the permanent bridge to the future can be established."
—paper on the future of girls' sports in New York State, delivered at a symposium on medical aspects of sports.

Readers are invited to contribute items of 100 words or less to this column. Contributions should be mailed to MEDICAL TRIBUNE, *110 East 59th St., New York, N.Y., 10022.*

Australian Court Upholds Unborn Child Rights

Medical Tribune World Service

MELBOURNE, AUSTRALIA—An unborn child acquires legal rights as early as seven weeks after conception and can later sue for damages suffered while it was in the womb, according to a unanimous decision by the Supreme Court of the State of Victoria.

The decision is regarded in medical and legal circles here as a setback to the campaign for reform of Australian abortion laws. It is believed to be the first ruling under Anglo-Saxon law to define the rights of an unborn child.

Victorian Attorney General G. O. Reid predicted that the ruling would make matters tougher for advocates of easier access to abortion, not only in Australia but in other parts of the world.

"The judgment justifies the point of view of many people who have opposed a relaxing of the laws concerning abortion," he said. "People who are urging change have said that a fetus is not a living thing."

The judgment was in favor of Sylvia Watt, born in the Royal Women's Hospital, Melbourne, on January 4, 1968. Eight months earlier, her mother, British-born Sylvia Alice Watt, had been left a quadriplegic from a car accident. Mrs. Watt, who with her family now lives in Petershead, Scotland, was awarded $91,397 damages for her injuries in 1968.

Early this year, the three-year-old Sylvia Watt also claimed damages. She sued through her father, Alexander Aitkin Watt, who also sought damages on his own behalf for the cost of caring for his daughter. The writ said that Sylvia was born with brain damage and suffered from epilepsy.

The writ alleged the child received her injuries either at the time of the car collision or because her mother was unable to have a normal pregnancy and normal labor.

Justice Gillard, giving judgment, said: "I can find no logical reason for rejecting the notion that the common law would protect a child within the womb against careless acts causing him or her injury. Disease and trauma happening at any time from the womb to the tomb apparently can affect one's well-being and future health.

"It is obvious that 'the person' who is conceived and developed in the mother's body is biologically the same 'person' who survives birth, lives, and finally dies. There can be no justification for distinguishing between the rights of a newly born infant returning home with his mother from hospital in a bassinet hidden from view on the back seat of a motorcar driven by his proud father and of a child within the womb whose mother is being driven by her anxious husband to the hospital on the way to the labor ward to deliver such child."

As a result of the court's ruling, Sylvia Watt's claim for damages was to go on to a Supreme Court jury for hearing.

The executive officer of the Royal Australian College of General Practitioners, Dr. F. M. Farrar, said in Sydney that the Victorian finding upheld the Australian Medical Association policy of opposition to abortion.

MEDICAL MEETING SCHEDULE

Domestic Meetings

Apr. 27-30 ...Tufts Alumni Weekend Meeting, *Boston*
Apr. 28-29 ...American Laryngological Association, *Palm Beach, Fla.*
Apr. 28-30 ...Society for Investigative Dermatology, *Atlantic City, N.J.*
Apr. 29-30 ...American Academy of Psychoanalysis, *Dallas, Tex.*
Apr. 29 .....American College of Psychiatrists, *Dallas, Tex.*
Apr. 30 .....American Society for Adolescent Psychiatry, *Dallas, Tex.*
May 1-3 .....Rocky Mountain Bioengineering Symposium and International I.S.A. Bio-Medical Sciences Instrumentation Symposium, in cooperation with Institute of Electrical and Electronics Engineers, *Omaha*
May 1-4 .....Southwestern Surgical Congress, *Albuquerque, N. Mex.*
May 3 .....Symposium Workshop on Foreign Medical Graduates, *Philadelphia*
May 4-6 .....American Association for Cancer Research, *Boston*
May 5-7 .....South Dakota State Medical Association, *Huron*
May 5-7 .....North Dakota Medical Association, *Minot*
May 6 .....American College of Psychiatrists, *Dallas, Tex.*
May 7-11 ....New York State Academy of Family Physicians, *Kiamesha Lake*
May 8-12 ....Ohio State Medical Association, *Cincinnati*
May 12-13 ...University Association for Emergency Medical Services, *Washington, D.C.*
May 12-13 ...Northwest Association of Physical Medicine and Rehabilitation, *Carmel, Calif.*
May 11-13 ...American Medical Electroencephalographic Association, *New Orleans*
May 12-13 ...Northwest Association of Physical Medicine and Rehabilitation, *Carmel, Calif.*
May 20 .....Vermont State Medical Society, *Montpelier*
May 22-23 ...Ambulatory Pediatric Association, *Washington, D.C.*
May 23-26 ...American Pediatric Society, *Washington, D.C.*